A STUDY ON THE IMPACT OF HIV/AIDS PEER EDUCATION PROGRAM ON THE MANAGEMENT OF HIV AND AIDS AT THE KENYA PORTS AUTHORITY (KPA)

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Josephine Marura Kitala Date: March 2011

Abstract

This study examines whether the HIV/AIDS peer education program has had an impact in the management of HIV/AIDS at the Kenya Ports Authority. It also aimed at determining how effective the peer education program is within the company from peer educators' point of view.

The study was a non experimental quantitative research. For the purpose of this study, the survey method was used. The study focused on 75 employees of the Kenya Ports Authority, aged between 20 and 55 years. Thirty male and female employees who have undergone peer education sessions and thirty who had not undergone the sessions and 15(fifteen) trained peer educators based at the head office of the Kenya Ports Authority in Mombasa, Kenya; participated in the study. The employees were randomly selected for the study.

Data were collected by means of a questionnaire which comprised of two sets of questions, one filled by respondents who had attended peer educations sessions and those who had not, and a second set of questions completed by the trained peer educators. Data analysis was done by means of SPSS with tables generated in SPSS and the output charts done in MS Excel.

The responses given by the respondents provided an understanding of the knowledge and attitudes of the targeted group towards HIV/AIDS, due to their participation or not in the peer education program; while the responses from the trained peer educators were used to evaluate how effective the program was from their perspective

Although inferential statistical analysis was not conducted, the findings seem to indicate that the HIV/AIDS peer education program had increased respondents HIV/AIDS knowledge levels and participants had acquired positive attitudes towards HIV/AIDS. However, A similar study to this needs to be conducted on a larger scale to either confirm or reject the findings of this study and to ascertain the impact of the peer education program in a workplace.

Opsomming

Hierdie studie het ten doel gehad om te bepaal of die MIV/VIGS-portieropleidingsprogram impak gehad het op die bestuurswyse van MIV/VIGS by die Keniase Hawe-owerheid. Dit het ook probeer vasstel hoe doeltreffend die portieropleidingsprogram binne die maatskappy is as dit uit die hoek van ‘n portieropvoedkundige in oënskou geneem word.

Die studie het nie-eksperimentele, kwantitatiewe navorsing behels en die opname-metode is vir die doel daarvan ingespan. Die studie is gerig op 75 werknemers van die Keniase Hawe-owerheid wie se ouderdom tussen 20 en 55 jaar gewissel het. Dertig manlike en vroulike werknemers wat portieropleidingsessies meegemaak het, 30 (dertig)wat nie sulke sessies gehad het nie, en 15 (vyftien) opgeleide portieropvoedkundiges verbonde aan die hoofkantoor van die Keniase Hawe-owerheid in Mombasa, Kenia, het aan dié studie deelgehad. Hulle is na willekeur vir die studie gekies.

Data is deur middel van ‘n vraelys ingewin wat uit twee stelle vrae bestaan het – een vir voltooiing deur respondente wat die portieropleidingssessies meegemaak het asook diegene wat dit nie bygewoon het nie, en die ander wat deur die opgeleide portieropvoedkundiges beantwoord is. Data-analise is deur middel van SPSS uitgevoer met tabelle wat in SPSS gegenereer en uitsetkaarte wat in MS Excel gedoen is.

Die antwoorde wat die respondente verskaf het, het insig gebied oor die kennis en ingesteldhede teenoor MIV/VIGS van die geteikende groep as gevolg van hulle deelname al dan nie in die portieropleidingsprogram terwyl die antwoorde van die opgeleide portieropvoedkundiges toegepas is om te evalueer hoe doelmatig die program – uit hulle perspektief beskou – was.

Hoewel afleibare statistiese analise nie gedoen is nie, wil dit voorkom of die bevindinge daarop dui dat die MIV/VIGS-portieropleidingsprogram die kennisvlakke van respondente verhoog het en deelnemers se ingesteldheid teenoor MIV/VIGS positief beïnvloed het. Dit is egter nodig dat ‘n soortgelyke studie as dié op groter skaal gedoen word om of die bevindinge van hierdie studie te bevestig of te verwerp, asook om die impak van die portieropleidingsprogram in ‘n werkplek te bepaal.

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CHAPTER 1: INTRODUCTION

1.1 Background and Rationale

Kenya Ports Authority (KPA) is a statutory body under the Ministry of Transport. It was established by an Act of Parliament on 20th January 1978 with a mandate to maintain, operate, improve and regulate all scheduled seaports situated along Kenya's coastline. The Authority is responsible for the operation and management of the port of Mombasa, other small seaports, Inland Container Depots in Nairobi and Kisumu and a liaison office in Kampala that caters for all transit countries.

The HIV/AIDS pandemic has impacted negatively on KPA through loss of skilled and experienced manpower of all cadres, loss of man hours due to prolonged illness among staff, absenteeism, reduced performance, increased stress, stigma and discrimination among other ways. The pandemic has therefore exerted pressure on its' limited resources. It is also significant to note that Coast province where KPA operates ranks third in HIV infections with an estimated 135,000 persons (8.1% of its population) infected (KAIS, 2007).

Kenya Ports Authority's work place program is one of the projects supported by the Federation of Kenyan Employers as an implementing partner. The company first experienced HIV/AIDS as a challenge in the 1980s when the first few cases were registered in the country. With a work force of 5400 employees and 19,000 registered dependants, the corporation currently provides care to all the employees and their dependants including antiretroviral therapy. The Anti retroviral Therapy program is supported by the company budget and Government of Kenya through National AIDS and Sexually Transmitted Infections control program.

The initial response for a peer education program at the Kenya Ports authority came from Kenya Ports Authority medical officers, who persuaded senior management to begin a prevention program. The Kenya Ports Authority management decided to train 48 peer educators in 1995. The majority of peer educators were trade union members. The reasoning

behind this decision was that union peer educators were in regular contact with other employees and were best suited to create awareness about HIV/AIDS.

The Peer educator program seemed to experience many problems at inception. It appeared that peer educators worked without any defined plan; meetings were irregular; and the response was passive. Passive responses may have been to an array of factors. Firstly, peer educators were appointed without consultation with the trade unions, which may have hampered roll out of the program. It also seemed that the stigma associated with the disease "carried over" to people involved in prevention efforts, which may have resulted in unionists trained as peer educators to carry out their tasks halfheartedly, for fear of losing elections. In addition, a retrenchment program was going on in KPA at the time, which also seemed to contribute to peer educators not wanting to be involved with the HIV program as many feared Management would retrench staff that were HIV positive or associated with HIV.

Despite these early setbacks, the KPA peer education program is still running. Currently, a need exists for evaluating the Program's success and as a result Kenya Ports Authority ability in effectively managing HIV/AIDS at the workplace.

1.2 Research Problem

The purpose of this study is to determine the impact of HIV/AIDS peer education program on the management of HIV and AIDS at the a designated workplace Kenya Ports Authority (KPA)

1.3 Significance of the Study

The results of this study aims to highlight the successes and pitfalls of the KPA Peer Education Program. The findings of this study might help the Medical Department at KPA (who is responsible for the Peer education program) to ensure the Program's sustainability and relevance in the future.

On a broader scale, the results of this study might aid other workplaces wanting to implement peer education programs by acting as a guiding tool for developing best practice guidelines on implementing peer education programs.

1.4 Research Objectives

This research study attempts to:

- explore the extent to which the HIV/AIDS peer education program conducted by the trained peer educators have impacted on the knowledge and attitudes of the KPA employees who have attended such sessions;
- establish how successful program has/is being implemented and the challenges thereof;
- determine the attitudes of the peer educators towards the peer education program
- In order to highlight the successes and pitfalls of the KPA Peer Education Program.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction to Literature Review

In this literature survey, peer education will be unpacked by firstly looking at the definition of peer education; then we will look at the role of a peer educator; and the components of a peer education program. The literature survey will also look at the advantages of peer education programs, the challenges facing peer education programs and will also review the effectiveness of peer education programs. The chapter provides a brief background on the KPA peer education program, lastly, a summation of the ideas presented in this literature survey will be given.

2.2 What is Peer Education?

In this section, we will define peer education by looking at various definitions presented in the literature pertaining to HIV/AIDS Peer Education.

In practice, peer education has taken on a range of definitions and interpretations concerning who a peer is and what is education (e.g. advocacy, counseling, facilitating discussions, drama, lecturing, distributing materials, making referrals to services, providing support, etc.) (Shoemaker et al 1998; Flanagan et al 1996).

Merriam Webster's Dictionary, (1985) has defined peer education as a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. The English term 'peer' refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status". The term 'education' (*v*. educate) refers to the "development", "training", or "persuasion" of a given person or thing, or the "knowledge" resulting from the educational process

Another definition offered by a document by the horizon project (undated) defines peer education as an approach that involves training and supporting members of a given group to affect change among members of the same group. The actual mechanism of implementing the

program varies widely as does the meaning of peer and education. The word 'peer' means one that is of equal standing with another based on age, grade or status. The word 'education' means the development, training of, or the knowledge resulting from educational process.

The USAID manual (2009) on APHIA Comprehensive Workplace Programs defines peer education as a process that involves similar people learning together in an informal way. It further states that peers in a workplace are people who are similar to one another in age, background, job roles, experiences, interest and values. Therefore in the same view, a peer educator in the workplace is someone who shares these attributes, is trained to facilitate the discussions on HIV/AIDS risk behaviour, and leads his or her peers in the examinations of solutions; making peer educators the link between the program and the target population.

Summarizing from the quoted literature, we have observed that peer education has taken on a range of definitions and interpretations; for the purpose of this research project peer education will be defined as "the process of sharing information among members of a specific community to influence behaviour or to achieve positive health outcomes".

2.3 The Role of Peer Educators

In this section, we will clarify what a peer educator does, with whom he/she works with and what support he/she expects. The section will explain what peer education is and why it is an important part of an HIV/AIDS prevention and care program especially in the workplace.

Peer education typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programs and policies *(UNAIDS, 2000).*

A UNAIDS (1997) Community mobilization and AIDS, technical update, outlines some of the roles that a peer educator performs as follows:

Awareness-raising: In addition to formal and informal peer education activities, peer educators are involved in awareness-raising activities, presentations, advocacy, community mobilization, and work with the media and other mass actions. Awareness-raising activities are not in themselves peer education as contact is not repeated, and they can be made with people of differing ages, status and background and can also be made with very large numbers.

Behaviour change communication: Through this interactive process, the peer educator provides the target population with basic facts about HIV and AIDS, this gives the target population opportunities to develop skills for personal protection and encourages them to access appropriate services and products in order to maintain and develop safer practices.

Community mobilization: In HIV prevention, community mobilization is a process through which community members come together to address their individual and collective vulnerability to HIV and AIDS. Community members identify their own concerns, participate in decision-making, evaluate the results and take responsibility for both success and failure.

Cultural mediator: Here the peer educator acts as a person who is able to link two cultures e.g. a gay man who is also a Red Cross Red Crescent volunteer, and is able to facilitate understanding and build trust between the two cultures.

Gatekeeper: A peer educator can be a person or people outside a peer group who may influence or control access to particular group, e.g. brothel owners or pimps may be the gatekeepers of some sex workers, while factory managers or owners may be the gatekeepers of factory workers.

The AIDSCAP manual (undated) on how to create effective peer education programs, gives some of the critical roles or activities expected of the peer educator as follows:

Increase Awareness of HIV and STDs among Peers. These include conducting informal small group discussions about HIV/AIDS**,** organizing and conducting formal group discussions about HIV/AIDS, teaching peers about reproductive health and STD detection and treatment. It can

also include organizing meetings and educational sessions, participating in World AIDS Day and other public events, holding regular meetings, distributing educational materials, displaying posters and other educational materials, presenting video screenings, designing/developing educational materials, or performing dramas and organizing sports events.

***Motivate and Support Behaviour Change*.** These include, talking to peers one-on-one, teaching peers how to do a personal risk assessment, teaching peers how to negotiate safer sex (including condom use), providing individual counseling, and recommending or referring peers for HIV testing

Condom Promotion, Condom Distribution and Education Activities. These activities include distributing free condoms or selling condoms, giving condom demonstrations, teaching condom use (buying, storing, opening, using, disposing) skills, making visits to hospitals or homes of AIDS patients, supporting people affected by HIV/AIDS and teaching peers about home care.

Activities Related to Care and Support of People Living with AIDS. This involves providing referrals to health care facilities, and taking part in income generating activities with people living with HIV/AIDS.

Peer educators can also help raise awareness, provide accurate information, and help their peers develop skills to change behaviour. Some of the ways they can do this include:

- leading informal discussions;
- video and drama presentations;
- one-on-one time talking with fellow students;
- handing out condoms, leaflets and brochures; and
- offering counseling, support and referral to services (*unicef.org/life skills; undated*).

The research findings of *"Talking About AIDS: A study of informal activities undertaken by workplace HIV/AIDS peer educators in a South African company"* by David Dickinson, associate professor at Wits Business School, sheds some light on the often confidential and intimate interactions that take place between peer educators and their peers.

Some key points emerged from the research into this particular group of peer educators:

- Common topics are condoms and femidoms and open talk on HIV/AIDS.
- Peer educators respond to "sexual networks" - for example, a miner who has a wife at home and a girlfriend near the mine - and identify the "pressure points" of these networks where HIV transmission can be limited.
- Peer educators are taken more seriously and have more power if they participate in workplace structures such as unions.
- Most informal encounters occur because the peer educator is known and is approached by peers.
- Most peer educators are African which contributes to the "racialising" of the epidemic. More peer educators who are white are needed to counter this and to prevent prevalence levels rising among whites.
- In the absence of a cure from western medicine, many people continue to hold alternative health beliefs in the treatment of HIV/AIDS. This creates complex problems for peer educators. Greater collaboration with alternative health practitioners is needed.
- Peer educators' oral language skills are extensive but ability to read and write is mixed. Training needs to be tailored to match the true literacy levels of peer educators.
- Sometimes unproductive interactions such as "soap operas", which drain the energy of peer educators, or uncreative, formal activity which alienates peers, occurs between peer educators and peers.
- Peer educators benefit from regular meetings with each other.

It is an advantage to use Peer Educators because of their peer status. They are a normal part of other individuals' lives and can understand through shared experience what those individuals value, aspire to, and feel frustrated by. HIV/AIDS peer educators have been used in a wide variety of settings where physical and socio-cultural access is difficult for outsiders. Peer educators also have the advantage of being able to communicate effectively because they understand the language and patterns of communication of those who they seek to influence. They can be seen as interpreters who render technical information about HIV/AIDS into forms

that their peers can understand, making it clear how HIV/AIDS can affect workers and their families (Dickinson, 2005).

Dickinson (2006) states that within companies, the industrial relations division between management and workers is recognized by use of peer educators; and so messages on HIV/AIDS will be more effective if delivered by peers at all levels of the company. In the context of HIV/AIDS in the workplace, peer educators can be seen as a third channel of communication, in addition to union and management communication structures. Significant mobilization of peer educators has occurred as part of the best-practice responses of large companies, though stronger structures appear to be associated with effective, often localized, partnerships between rank-and-file volunteers who have an organizational capacity and company managers who can provide the necessary resources.

Peer educators are expected to conduct a number of functions that are articulated with different degrees of clarity within company HIV/AIDS programs. These include assisting with company-wide initiatives, such as voluntary counseling and testing drives; giving formal presentations to colleagues on HIV/AIDS during team or other meetings; informal discussions; providing a first line of confidential advice to co-workers; referring where necessary to other sources of help such as the occupational health practitioners; and engaging in community projects. (*UNAIDS, 1999*)

Thus, summarizing from the quoted literature, we have identified the roles of the peer educators as both formal and informal, and mainly involve imparting knowledge and the understanding of the nature of the disease and the resources available. We have also seen that peer educators work with their peers and expect participation from the peers; peer education thus plays an important role in imparting knowledge across the spectrum of HIV/AIDS management.

Peer education constitutes a significant part of HIV/AIDS prevention programs as it is at the heart of educational activities and provides considerable information and support through informal activity. We have also seen the importance of peer education programs at the workplace: peer education prepares and channels employees into different aspects of the HIV/AIDS workplace program.

2.4 Components of Peer Education Programs

This section will look at the different components of the peer education program, highlighting some of the peer education methodologies and activities used to promote and foster HIV-related behaviour change.

There is a considerable literature on peer education in the context of HIV/AIDS. Some of the critical issues identified are the cultural specificity of peer education activities *(Shuguang, Van de Ven, 2003)* the question of what characteristics constitute peer status *(Wolf, Bond 2002; Ozer, Weinstein and Maslach 1997)*, the appropriate level of involvement in a program that they participate within *(Lewis et al. 2002; Campbell 2004)*, and the degree to which they influence peers or, in fact, change or benefit themselves *(Strange et al 2002; James 2002)*. From these studies, it was ascertained that peer education programs should be tailored to the age, gender, sexual orientation sector characteristics and behavioural risk factors of the target population and its cultural context; they should also be delivered by trusted and respected individuals. This is why HIV/AIDS peer education has been found to be particularly effective, as it has the involvement of people living with HIV/AIDS in the design and implementation of programs.

Fighting HIV/AIDS in the workplace: A Company Management Guide developed by the International Finance Corporation (IFC) and the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) (undated) states that any peer education program should consist of a retention and support plan for peer educators. This should include the provision of a plan of topics, materials, and periodic refresher training. It further states that the quality and effectiveness of HIV/AIDS peer education programs can be enhanced by compensating peer

educators; involving them in the design of training curriculum and materials; and linking the education program to other services such as access to condoms, medical care, and voluntary HIV counseling and testing. Peer educators can also become involved in community education activities.

Dickinson & Kabelo (2007) point out that workplace peer education programs are formally structured as vertical communication programs run by HIV/AIDS managers who use the peer educators to impart knowledge and training sessions to other employees on assigned topics. Additionally peer education takes place on an extensive horizontal communication style with peers both inside and outside the workplace; effects that are often categorized as informal activity.

A report entitled *Peer education and HIV/AIDS: Past experiences future directions* from the Horizon Project presented findings from a project designed to better understand the operational issues facing peer education program managers. (The Report identifies some of the key components of a peer education program as:

- Peer education program design should be informed by formative research that involves the intended audience and other program stakeholders;
- The extent to which the peer education curriculum (activities and content) is standardised should be determined by the needs of the intended audience;
- Messages should be reinforced through different activities and intervention channels; and
- Peer education programs should adjust methodology and content to incorporate results from on going monitoring and evaluation that includes input from peer educators

From the literature reviewed, we have seen that peer education programs should be modelled appropriately taking into account the participants and should be flexible to accommodate the participants' uniqueness. Thus, an appropriate peer education program that can be an effective strategy to reach out to for example, workers in support and prevention of HIV/AIDS and that

can positively affect HIV/AIDS education and promotion activities should be developed using a consultative approach involving the management, peer educators and the target audience.

2.5 Advantages of Peer Education Programs

In this section, we look at some of the reasons that make peer education a popular intervention approach, concentrating on its effectiveness as a prevention approach in a workplace setting.

According to UNAIDS (1999), peer education programmes are widely implemented by program managers in their prevention programs because:

- Peer education is based on the behavioural theory which asserts that people do not make changes of scientific evidence or statistics but are more likely to change their behaviour if people they know and trust persuade them to do so. Peers by definition, are similar in age, background, experiences and interests, and so people are more likely to listen and follow advice from peers

- Peer education helps to break down barriers by allowing people to discuss sensitive matters without fear this makes the use of peer education an important component of effective HIV/AIDS education programs ,

- In the context of the HIV/AIDS workplace programs, peer education involves the training of male and female workers to facilitate discussions with their co-workers with the goal of encouraging them to examine and change their high-risk behaviours. HIV/AIDS workplace programs are set up to provide comprehensive prevention, care and support interventions. Peer education is an important and effective way to do this because before individuals can reduce their level of risk or change behaviour, they must first understand the basic facts about HIV/AIDS assess and modify their attitudes, learn new skills and know how to access appropriate services. They must also perceive their environment as supportive of behaviour change and the maintenance of safe behaviour. A workplace peer education program contributes to creating such an environment.

- Peer education is cost effective option for HIV/AIDS as it helps in reducing new infections; it capitalizes on individuals who will encourage their fellow colleagues to consider changing their current high-risk behaviours and can be initiated rapidly to reach a large number of workers. The creation of such a program improves the morale of workers who see their employers and workers' representatives contributing to the protection of their rights, health and well-being.

- Peer education is a widely used and implemented strategy that is accepted by the target audience. It is Participatory nature and therefore it facilitates the involvement of the target audience

In an abstract to the international AIDS conference (2002) entitled *Role of peer education in HIV/AIDS prevention at the workplace,* P.S Kallyan argues that Peer education is an effective strategy to reach out to workers in support and prevention of HIV/AIDS at the workplace as it can have a positive influence on HIV/AIDS education and promotion activities. Thus, the presence of an appropriate peer education program can help develop a lasting partnership and collaborative activities at the workplace. Maximum impact in HIV/AIDS prevention and education will be achieved if educational messages and prevention activities are delivered in a complimentary, regular and updated manner, with peer education at the workplace.

Since workplaces feature many people with common socio-cultural, economic and education characteristics, peer education has proven to work well. Employees are generally easy to reach and participation can be high, especially if sessions occur during working hours (*USDOL PEPFAR, 2009*).

Workplace peer education programs as outlined by USAID (2009) are advantageous because:

- Workplaces are communities that are well defined with organizational structures hierarchies and policies, that makes it is relatively easy to establish peer education programs in an environment where people with common demographic characteristics

can be easily identified and organized. Company workplaces are legal and open environments in which communication should therefore not be problematic.

- Interpersonal communication is possible because workers in workplaces are relatively small in number compared with many other communities and, as a result, are relatively easy to organize interpersonal communications. Peers usually have a lot of credibility with their fellow workers, which make interpersonal communications even more effective.

- People are more likely to listen and follow the advice of their peers. Peers also have greater influence on each other than non peers, a significant factor in lending credibility to behaviour change messages. Peer educators and program beneficiaries can mutually identify with each other as individuals and as members of a specific sociocultural reality. Because of this identification, peer educators make strong role models for promoting the adoption of HIV preventive behaviour.

- Through peer education, peer educators can effectively carry out a range of HIV/AIDS education and other prevention activities with their co-workers.

- Others often appreciate action by the employer and worker leaders on HIV/AIDS. Being involved in the creation of peer education programs has the benefit of increasing the morale of workers, as they see their employers and workers representatives contributing to the protection of their rights, health, and well being.

- Peer education is cost effective for employers compared to the cost of lost productivity, absenteeism or retraining and payment of health benefits due to HIV/AIDS. Establishing a peer education program can save money by helping to reduce new infections through the balanced dissemination of messages; including those dealing with abstinence, mutual fidelity and condom use to promote HIV risk reduction. It is also important to

note that Peer education in the workplace thrives when it is directly linked to condom promotion, distribution, and other services.

Participants at an international consultation of peer educators held on April 1999, in Kingston Jamaica, came up with several key findings on peer education. Majority of the participants reported that most of their institutions had integrated peer education with other program activities in an effort to prevent HIV infections and provide care and support to people living with HIV/AIDS. While most of the respondents stated that their peer education programs were integrated with other interventions, several informants stressed that it was their peer education programs that linked these program activities and services together. Asked why their organizations selected peer education, informants reported a variety of beliefs and opinions:

- That peer education is a widely utilized HIV prevention strategy that is accepted and valued by both program audiences and stakeholders.
- That peer educators have physical access and socio-cultural access to intended audiences in their natural environments without being conspicuous.
- Peer education is based on behavioural theory which assets that people make changes not because of scientific evidence or testimonies but because of the subjective judgment of close trusted peers who have adopted changes and who act as persuasive role models for change.
- Peer educators are effective and credible communicators who have inside information of the intended audience and use appropriate language, terminology as well as non-verbal gestures to allow their peers to feel comfortable when talking about issues of sexuality and HIV/AIDS.
- Peer education is effective in promoting the adoption of preventive behaviour with regard to HIV/AIDS. Peer education is also a cost-effective intervention strategy because, its use of volunteers makes it inexpensive to implement and /or expand.
- Peer educators and their peers mutually identify with each other as individuals and as members of a specific socio-cultural reality. Because of this identification, peer

educators make strong role models for promoting the adoption of HIV preventive behaviour.

- Peer education was selected based on a needs assessment or pilot study with the target population that indicated that peer education would be an effective intervention strategy.

(UNAIDS, 1999)

In summary: We have seen that Peer education is a popular approach of HIV/AIDS prevention programs because it is participatory in nature and therefore facilitates the audience to take part that means making it accepted by the target audiences. Peer education programs allow peer educators to use their status as role models, to make their peers feel comfortable when talking about issues of sexuality and HIV/AIDS making it possible to use this approach to impart HIV/AIDS knowledge.

2.6 Challenges Facing Peer Education Programs

This section discusses some of the different challenges facing the workplace peer education program.

The USAID APHIA II coast program in Kenya indentified the following as the most common challenges facing workplace peer education programs:

- Resistance to discussing issues on STIs, HIV,AIDS and sensitive topics such as condom demonstrations
- Time constraints for group activities
- Lack of managerial support for peer education activities
- High turnover of peer educations since they are volunteers
- Large variations in peer skills and motivation
- Difficulty in evaluating the program and liking peer education efforts to behaviour change.

2.7 Review of the Effectiveness of Peer Education Programs

This section will review some of the published peer reviewed and non-peer reviewed literature that reveals some evidence of peer education's effectiveness in certain populations and contexts.

The West African Youth Initiative in Nigeria and Ghana uses peers to provide reproductive health and sexuality information and counseling to young males and females aged 12-24. Evaluation indicates significant positive effects on program participants' knowledge, perceived self-efficacy, and behaviour. A post-intervention survey found that after about 18 months of program activities, the target population showed increases in knowledge and the use of modern contraceptive methods, when compared to the baseline survey. The experimental group showed greater feelings of confidence in saying "no" to sex, in asking a partner to use condoms, and in buying contraceptives compared to those participants in the control group. More young people in the experimental group than in a control group reported that they had taken protective measures against STDs/HIV. These included abstinence, limiting the number of sexual partners, and the use of condoms (*Lane, 1997*)

In a CARE project in Kenya, Community Resources for Under 18's on STDs and HIV (CRUSH), survey results indicated that when compared to a control group of non-participants, the target group of out-of-school youth aged 12-18 displayed better knowledge, more positive attitudes, and signs of behavioural changes toward STD/HIV prevention following a peer-to-peer educational intervention (Chege, Avarand, Ngay, 1995).

In a Thai factory-based setting, single female adolescent workers involved in a peer-led education program demonstrated significant improvements in both knowledge and enabling skills as compared to their counterparts who were not exposed to this program. The program improved their skills in being able to discuss contraception with their partner, as well as their ability to assume responsibility for practicing contraception. (*Cash, Anasuchatkul, 1993*).

The importance of peer education is widely recognized. According to Wolf and Bond (2002), the perceived effectiveness of this strategy draws on research indicating that, generally any effective HIV/AIDS preventive strategy not only involves information but understanding and behavioural change and that similarity between the message source and recipients is vital to the ultimate impact of the message.

An initial evaluation of the federation of Ugandan employees HIV/AIDS program suggested that peer education interventions had positive effect on participants taking part in these interventions. Participants at sites where at least half of their peers were exposed to the program were eight times more likely to have used condoms consistently with at least one partner during the previous two months than those at sites where fewer than half were exposed to the intervention (*Family Health International, 2002).*

A study by Katzenstein et al (1998) revealed a 34% reduction in the rate of new HIV infections in 40 factories that participated in HIV workplace programs. This program consisted of a peer education component that was run alongside a voluntary counseling and testing program. A similar study of a workplace HIV/AIDS prevention and support program at a Tobacco processing firm in Zimbabwe, revealed that 92% of the workers interviewed indicated that their source of information on HIV/AIDS was the workplace-based HIV/AIDS prevention program at their company. The same study attributed the successes achieved by this program to the existence of counseling services at the workplace. The use of peer educators was also reported to have contributed to the success of this Program *(Kaseke, 2004)*.

Several peer projects have also been found to have impacted on peer educators:

- In the Jamaica Red Cross "Together We Can" Project, peer educators showed significant gains in knowledge about HIV transmission and were more knowledgeable on where young people can go to find help with STDs as a result of the Project. Most of the peer

educators also intended to delay their first or subsequent sexual encounters and to use condoms when sexually active (*Randolph, 1996*) as a result of the Project.

- A major study of 21 AIDSCAP projects found that 95% of peer educators had made changes in their own life and behaviour as a result of the Projects. This included a 31% rise in participants who were now practicing safer sex and/or were using condoms, 20% had reduced their number of sexual partners, and 19% had changed their attitudes in a positive way towards HIV issues (*Flanagan, Williams, Mahler, 1996*).

- There was a significant change in both attitudes and behaviours of Peer promoters working in PROJUVE, a youth project in Mexico as a result of the Program: 97% of those who were sexually active reported that they now used contraception. In addition, the Peer promoters showed higher levels of knowledge pertaining to contraceptive methods and STDs (as a result of the Program. (*Lobo, undated*)

In summation: Peer education is an effective strategy because firstly, many young people prefer to receive reproductive health information from peers rather than from adults. We have seen how a group of teenagers aged 12-18 displayed better knowledge, more positive attitudes, and signs of behavioural changes toward STD/HIV prevention following a peer-to-peer educational.

In addition, we have seen that peer education works when used as an intervention in a factory-based setting: single female adolescent workers involved in a peer-led education program demonstrated significant improvements in both knowledge and enabling skills when compared to their counterparts not exposed to this program. We have also observed that several peer projects have been found to have a positive impact on the peer educators themselves.

2.8 Kenya Ports Authority Peer Education Program

This section will give a brief background of the Kenya Ports Authority Peer education program; how it was started and how it is currently being run.

The peer education program at KPA was started in 1995 but by the late 1990s, the Kenya Ports Authority prevention program had lost its leadership and direction. In January 2000, Family Health International (FHI) met with senior management and senior union leaders to re-sensitize and motivate them and to build a supportive environment for the HIV/AIDS program.

Family Health International offered new information about sexual behaviours, sexual networks of employees and the current and potential impact of AIDS on Kenya Ports Authority operations. A new structure for the prevention program was put in place. The port was divided into six logical subunits, each treated as a discrete entity with Kenya Ports Authority focal persons and peer educators were recruited, (A focal person serves as a link between each section's prevention efforts and management).

A new contingent of peer educators were recruited and trained. One workplace peer educator was recruited for every 50 employees. Peer educators were recruited strategically to ensure balanced representation of various geographic and functional divisions of the port. These educators were drawn from the ranks of dockworkers, union representatives and various levels of administrative and management staff. Each peer educator organizes at least one group participatory outreach meeting every week. Role-playing, picture cards, short dramas and games are used to convey messages at these group meetings. Additionally, each peer educator informally discusses AIDS with at least 10 employees monthly.

One-minute "incomplete role plays" are the cornerstone of the participatory package used the Kenya Ports Authority peer educators. A typical one-minute role-play raises an important social issue but leaves it unresolved, hanging, frozen, at a dramatic, emotionally engaging moment. The cast then asks audience members to discuss the issue. Simple prizes, such as condoms or health literature, may be awarded during the games. The Kenya Ports Authority peer educators have been trained to facilitate interpersonal interaction and follow monitoring and reporting schedules and procedures that permit deeper inquiry into aspects of the epidemic. The peer educators are being trained to help participants explore their feelings and

real-life experiences and share Concerns with their groups. The goal is to change sexual attitudes and behaviours.

The peer educators also promote awareness offsite; symptoms and the need for prompt care, and refer individuals for treatment. Outreach activities are closely linked to intensive condom distribution, which occurs during peer-led educational activities. In one year, the peer educators distributed more than 65,000 condoms, which are also placed in strategic places such as restrooms.

The prevention program has been strengthened with an annual budget from the Kenya Ports Authority. This has enabled the Kenya Ports Authority prevention program to go beyond the workplace, into the community. The peer educators now conduct educational activities in residential areas as well.

In summarizing, the Kenya Ports Authority peer program is supported by Family Health International who assisted in its development.
The peer educators are drawn from all cadres of staff and participatory methods are used in the peer sessions.
The peer educators provide awareness to the employees and outside the company.

2.9 Summary of Literature Review

In this chapter we firstly looked at various definitions presented in the literature pertaining to Peer Education and defined peer education as the process of sharing information among members of a specific community to influence behaviour or to achieve positive health outcomes.

We then looked at the role of a peer educator and found that the role of peer educator are, both formal and informal, and mainly involve imparting others (peers) with knowledge and understanding of the nature of the disease and the resources available, we then discussed the

Components of a peer education program where we mentioned that the Programs should be tailored to the age, gender, sexual orientation sector characteristics and behavioural risk factors of the workforce and its cultural context, and that they should be delivered by trusted and respected individuals.

Then we discussed the advantages of peer education programs, and looked at the challenges facing peer education programs and noted that while peer education is one of the most widely used strategies in combating the HIV/AIDS pandemic, it also posses some challenges which should also be taken into account.

We then reviewed literature on the effectiveness of Peer education programs and lastly looked at a brief background on the KPA Peer education program.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter will outline the research design used by the researcher to collect the necessary data. Christensen refers to research design as the "outline, plan or strategy specifying the procedure to be used in seeking an answer to the research question.

3.2 Research Design and Method

This is a non experimental quantitative research. It is a descriptive research "in which the goal is to attempt to provide an accurate description of a particular situation" (Christensen, 2007). For the purpose of this study, the survey method was used because it is a nonexperimental technique often defined as a method of collecting standardized information by interviewing a representative sample of some population.

3.3 The Target Population

The study focused on the employees (60) and trained peer educators (15) of the Kenya Ports Authority.

3.4 Sample and Sampling Technique

Thirty male and female employees aged between 20 and 55 years who have undergone peer education sessions and thirty who had not undergone the sessions and 15(fifteen) trained peer educators based at the head office of the Kenya Ports Authority in Mombasa, Kenya; participated in the study. The employees were randomly selected for the study.

3.5 Data Collection

Data were collected by means of a questionnaire which will comprised of a two sets of questions, one to be filled by respondents who had attended peer educations sessions and those who had not, and a second set of questions to be completed by the trained peer educators.

Section 1 was a knowledge and attitudes questionnaire comprising of closed and open-ended questions (designed to give satisfactory answers to the main research question of the study) and was aimed at employees of KPA. It comprised of questions on the biographical information (age, gender, level of education and position/rank occupied) and it also comprised of statements (on the Likert scale) to assess the knowledge and attitudes of the targeted group towards HIV/AIDS. Areas covered by the questionnaire were basic facts about HIV/AIDS (transmission prevention etc); basic questions exploring common myths and misconceptions; and attitudes towards PLWAs. It was the intention of the researcher to separate the gathered data into two groups for those employees who have attended peer training sessions and those who have not. A comparative analysis was performed on the data obtained from the two groups in an attempt to compare any possible differences on knowledge and attitudes of these two groups.

Section 2 of the questionnaire comprised of questions for the trained peer educators so to evaluate the program from their perspective, and to establish how they ran the peer education activities.

The questionnaires were handed to the respondents and time was allowed for completion of the questionnaires. A maximum of one day was allowed to complete the questionnaire and the researcher personally collected the questionnaires from the respondents on the second day.

3.5 Data Analysis

Data analysis was done by means of SPSS with tables generated in SPSS and the output charts done in MS Excel. After the questionnaires came from the field, they were quality checked for completeness (were they fully filled in as required), coding was done for the open ended questions and thereafter a data capture template was made in SPSS where all the questionnaires data was captured. Cleaning of the data file was done by running frequency counts and cross tabulations. Once the data was ascertained to be clean the tables were generated using SPSS command syntax and exported to MS Excel where charts were done.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Introduction

This chapter will present the analysis and interpretation of the data obtained from the respondents of the study. According to Christensen, “the use of statistical analysis is necessary to reach conclusions regarding the results of the experiment we have conducted” (Christensen).

The chapter will firstly present the demographic profile of the respondents (peers and non peers). Then the responses to the knowledge and attitudes survey will be presented by doing a comparative analysis between the respondents that attended HIV/AIDS peer education sessions and those who did not.

For the purposes of this analysis the group who attended HIV/AIDS peer education sessions will be referred to as Group A, and those who did not attend such sessions will be referred to as Group B.

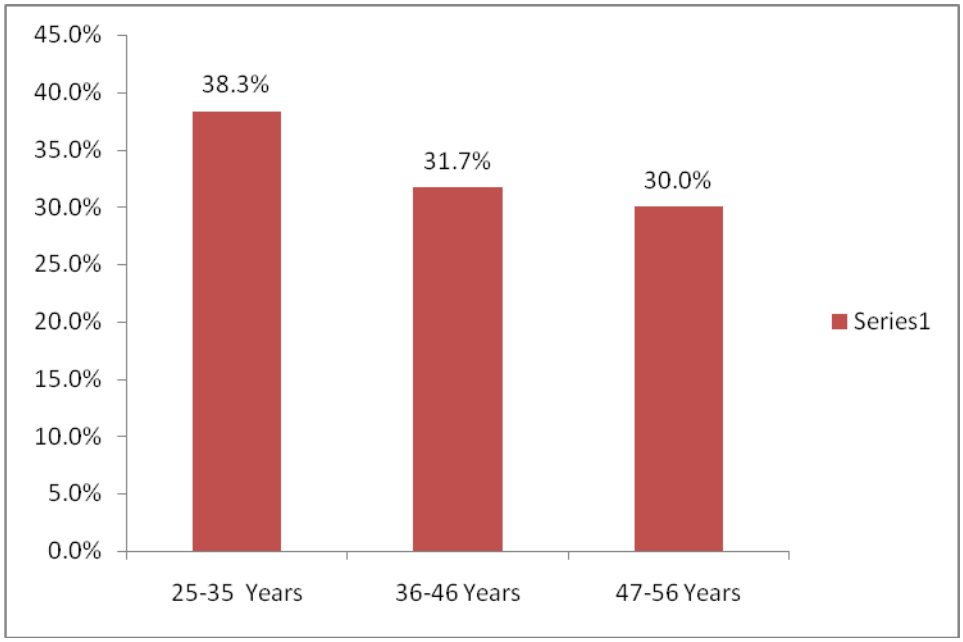
The chapter will also present responses of the peer educators in order to gauge the effectiveness of the peer education program.

Section 1

4. 2 Breakdown of Respondents Demographic Data

Q.1

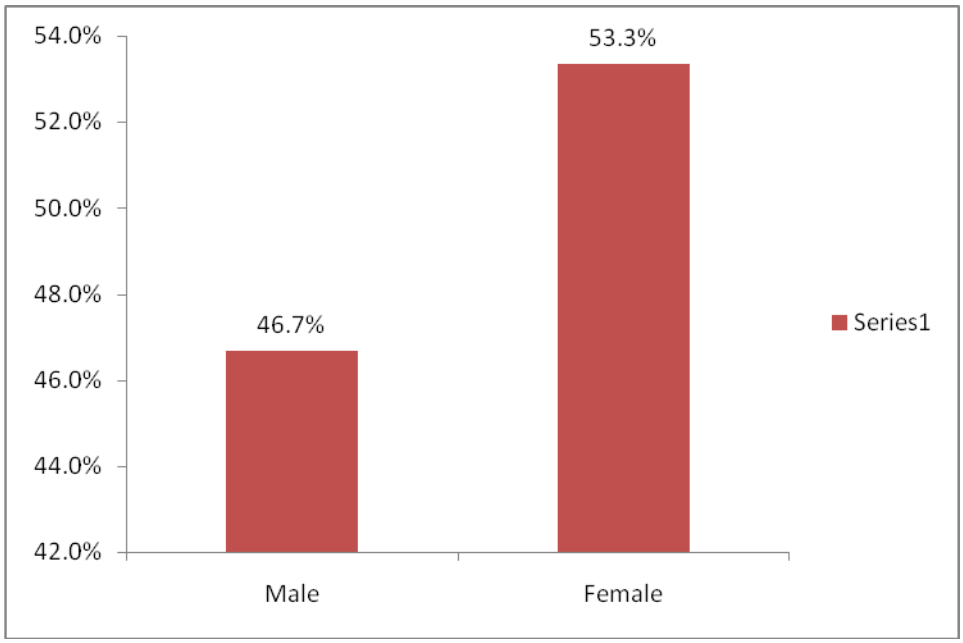
4. 1. 1 Figure 1: Age Distribution



The age distribution of the participants is a representation of the different age groups working at the Kenya Ports Authority. Majority of the participants fall in the age bracket of 36 – 46 years.

Q.2

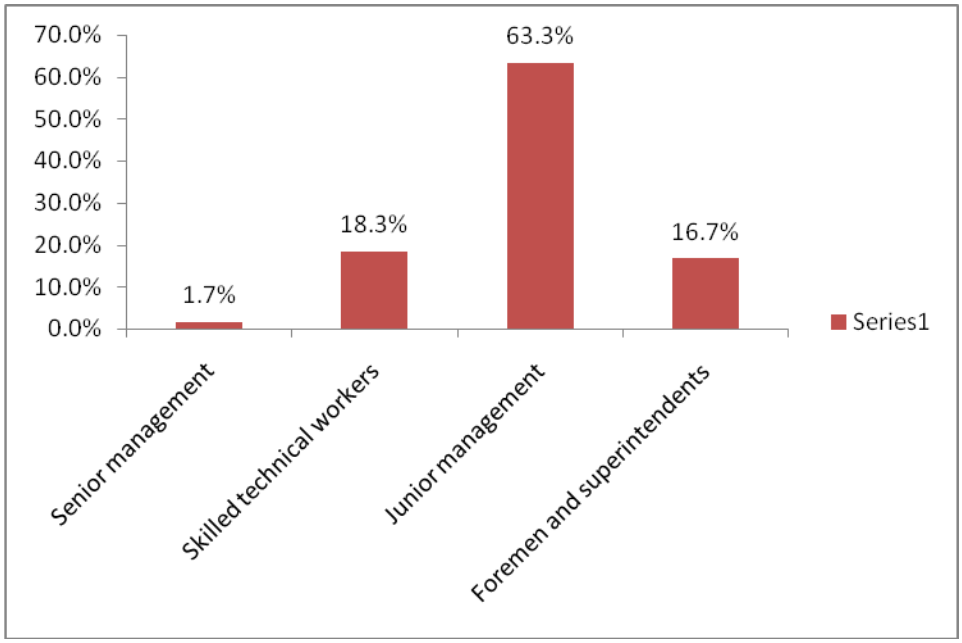
4. 1. 2 Figure2: Gender Distributions



There is an even representation of the two sexes in the study within the participants who took part in the study. The participants were randomly selected to participate in this study and there was no manipulation made to influence which gender the participants were and the respondents responses were all weighted the same without putting into consideration the gender

Q.3

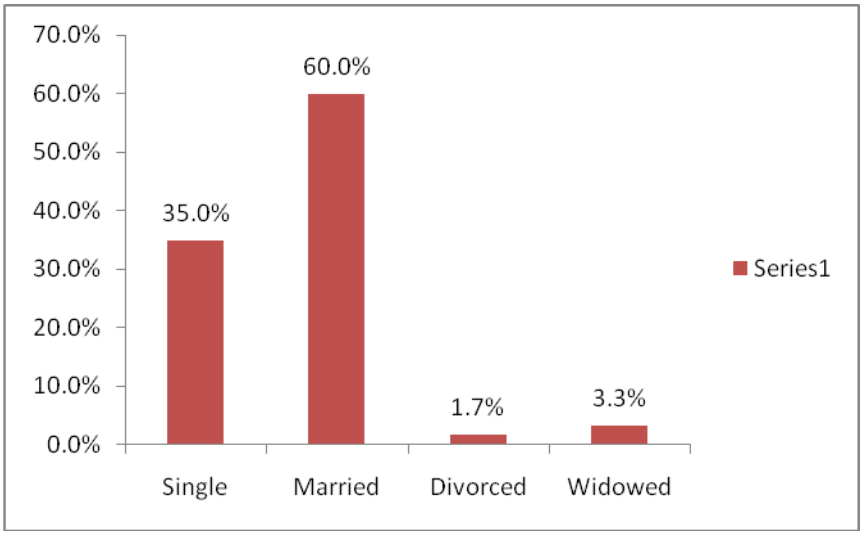
4. 1. 3 Figure 3: Job Level



Majority of the workers who took part in the study are junior management, these are officers involved in management of stores accounting, personnel and were not directly involved with the workforce like the foremen and superintendents.

Q.4

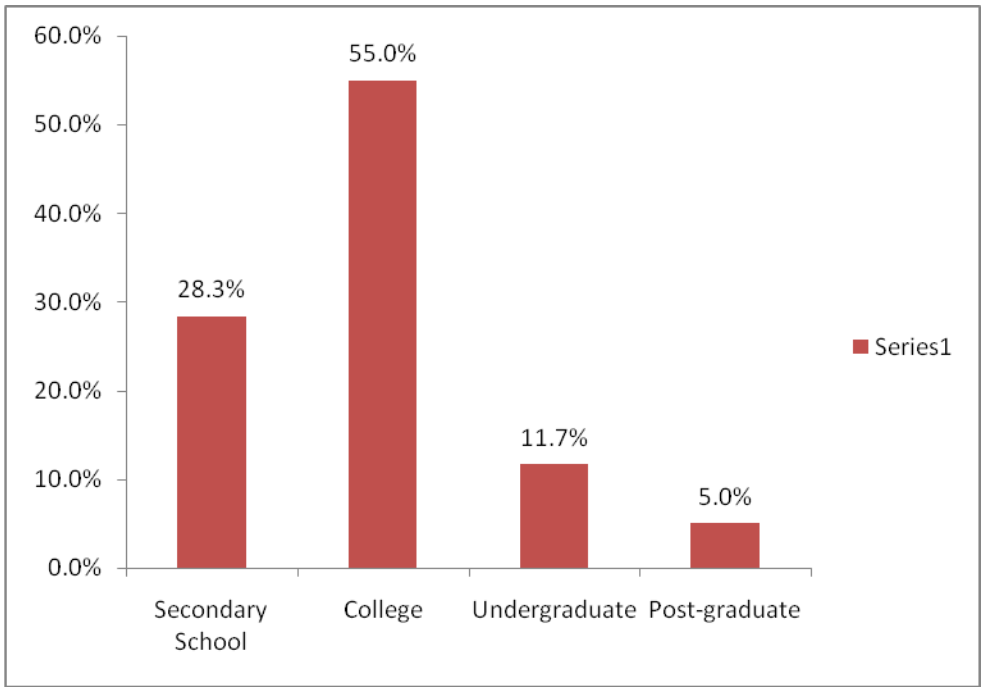
4. 1 .4 Figures 4: Marital Status



Majority of the respondents who participated in the study were married.

Q.5

4. 1 .5 Figure 5: Educational Level

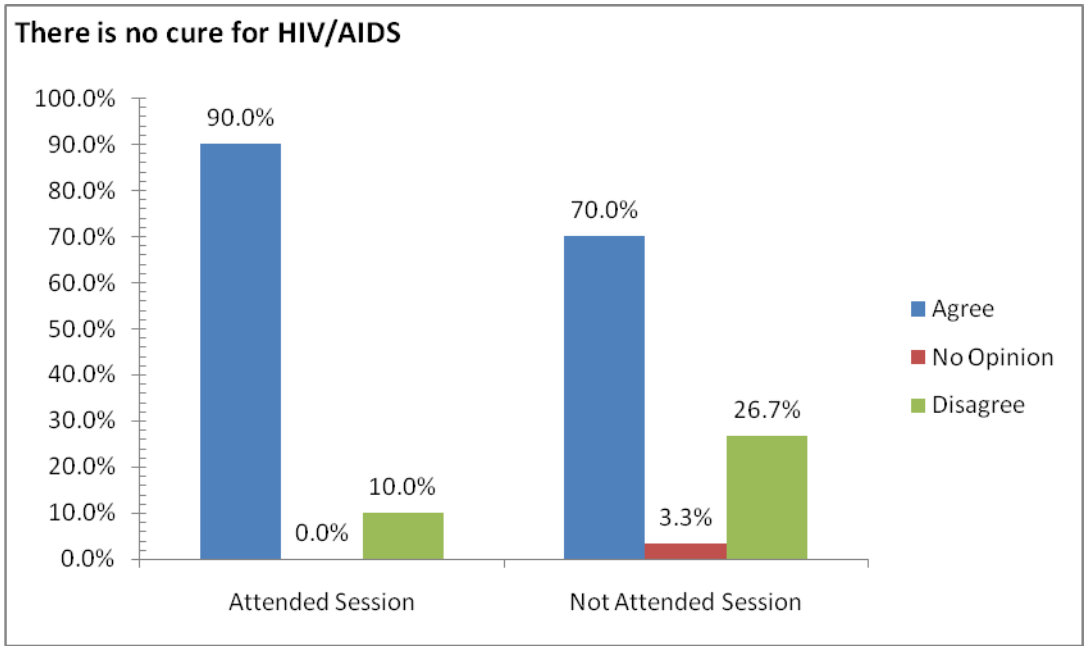


Majority of the respondents are college graduates, with qualification in courses like forklift operators, drivers of tug masters' crane/winch and fork-lift trucks, logistics management, freight management, occupational health and safety, clearing and forwarding, shipping management etc.

4. 3 Respondents HIV/AIDS Knowledge

Q.6

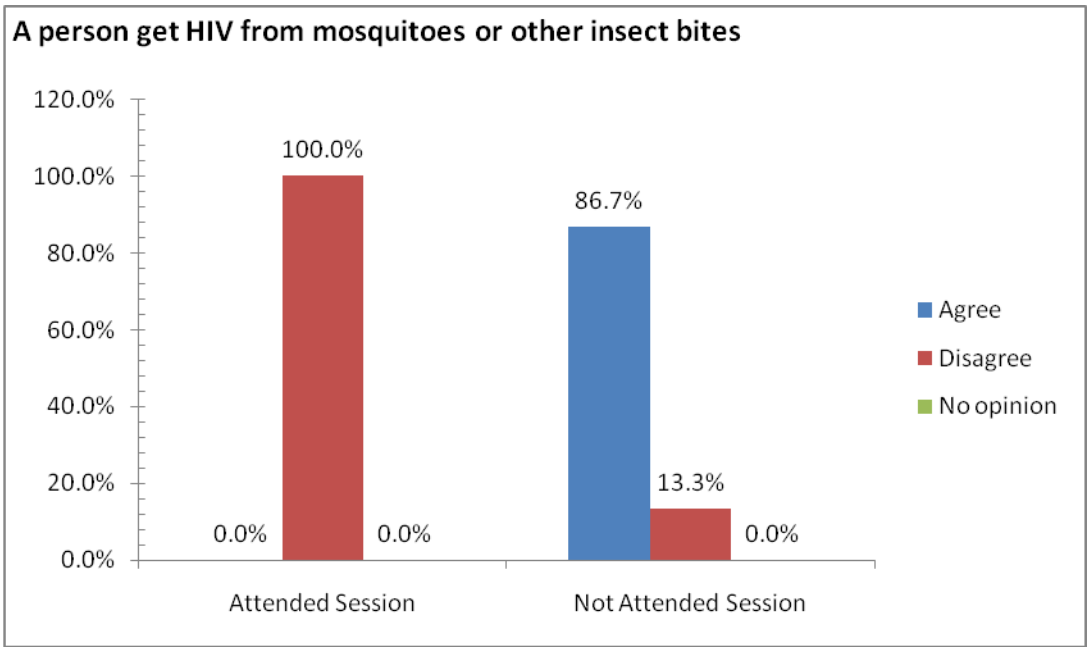
Figure 6:



The figure indicates that majority of the respondents from both groups agreed with the statement. Peer education helps provide accurate information on HIV/AIDS; currently there is cure for HIV/AIDS.

Q.7

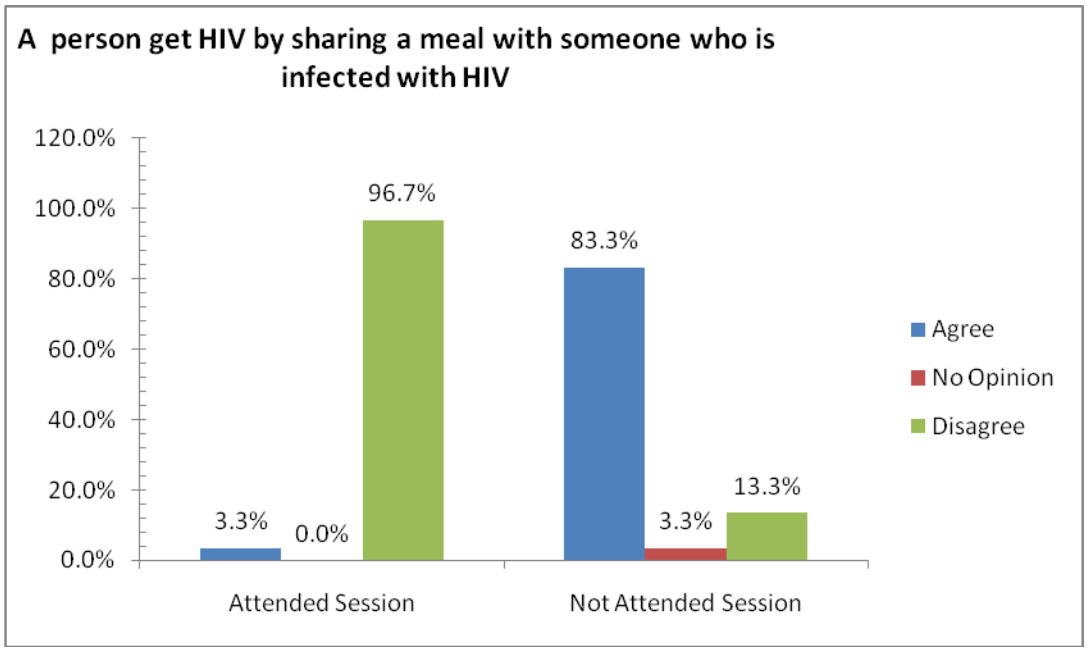
Figure 7:



All of the respondents from Group A disagreed with this statement and 13.3% of group B respondents disagreed.

Q.8

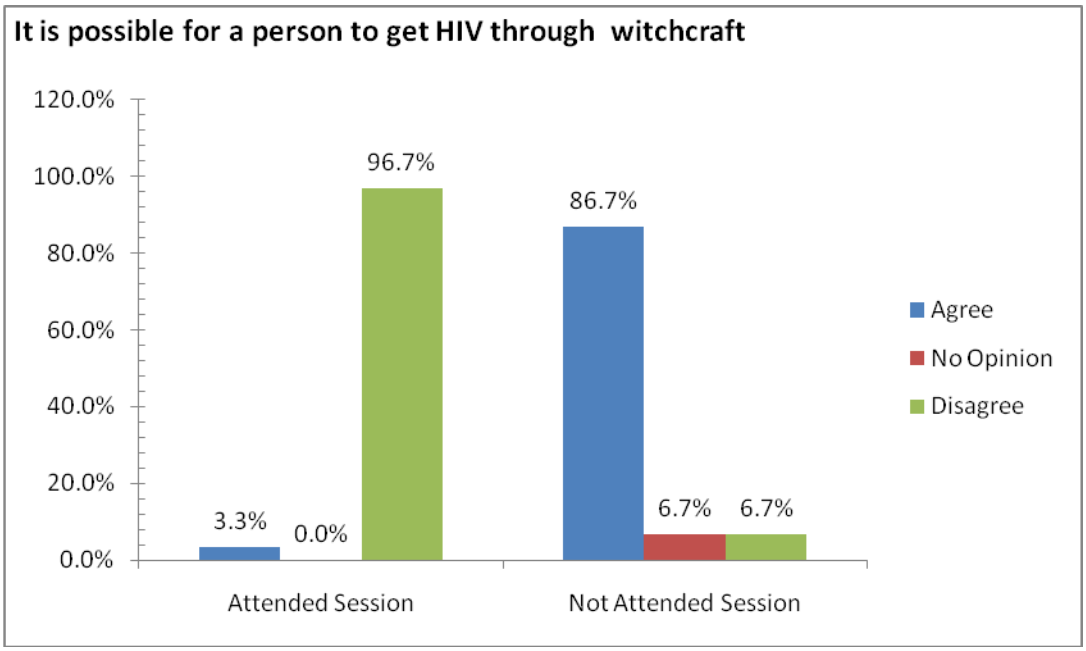
Figure 8:



The majority of Group A respondents (96.7%) disagreed with the statement while 13.3% of Group B respondents disagreed with the statement.

Q.9

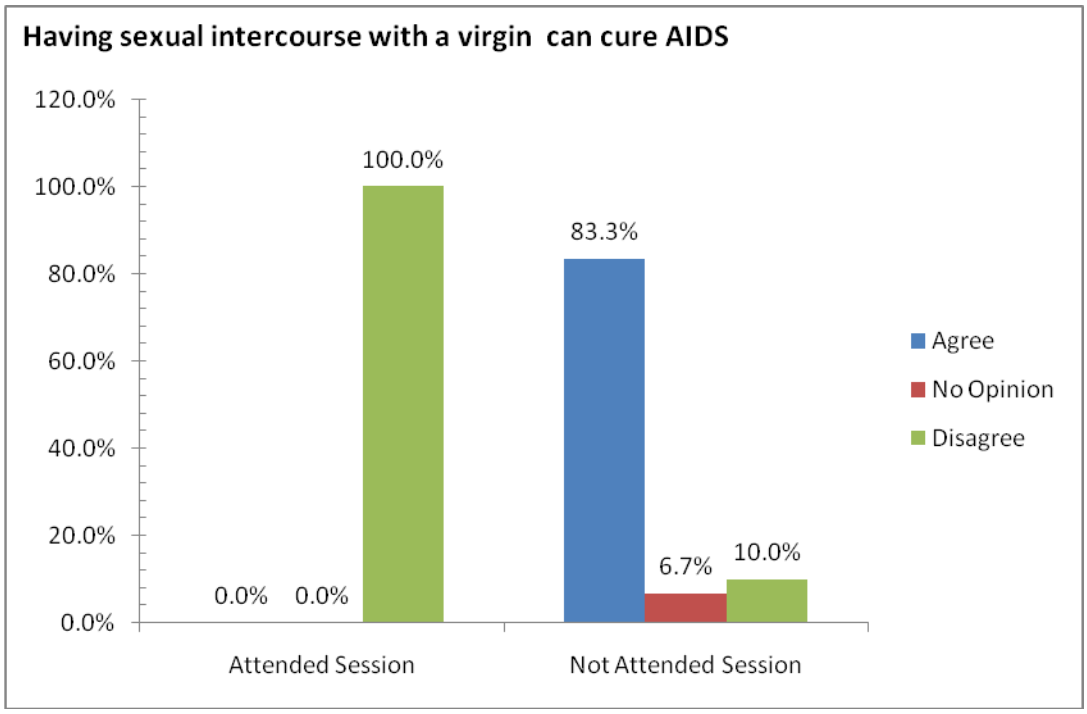
Figure 9:



The majority of Group A respondents (96.7%) disagreed with the statement while 6.7% of Group B respondents disagreed with the statement.

Q.10

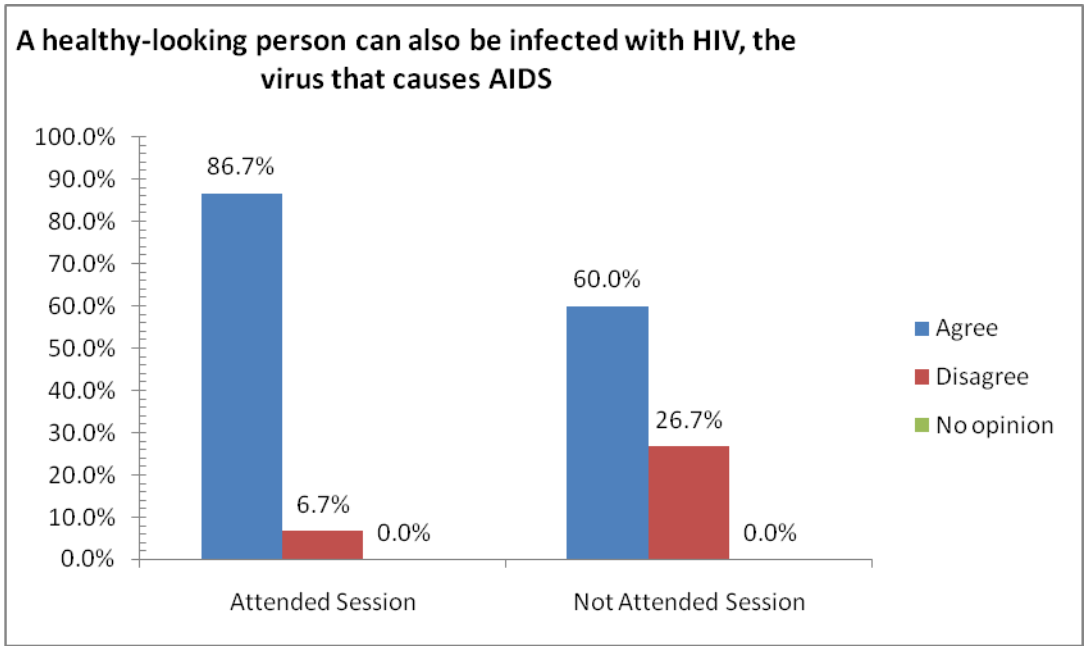
Figure 10:



All of Group A respondents agreed with the statement while 10% of participants in Group B agreed with the statement.

Q.11

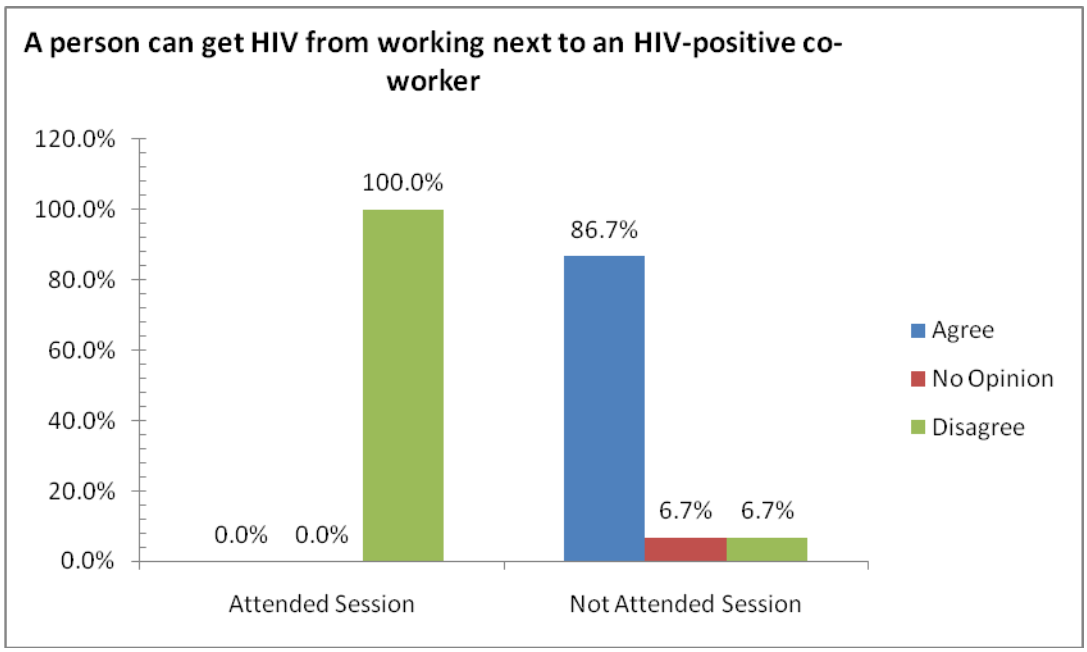
Figure 11:



The majority of the respondents from both groups knew that a healthy looking person can also be infected with HIV.

Q.12

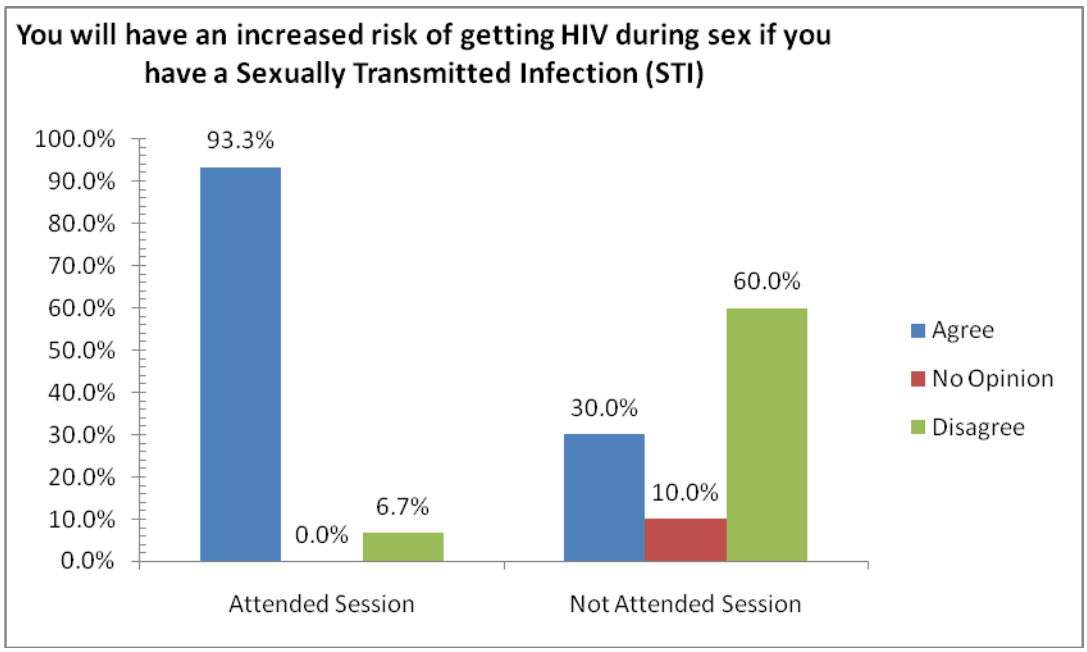
Figure 12:



The majority of participants in Group A disagreed with the statement while 6.7% of Group B respondents disagreed with the statement.

Q.13

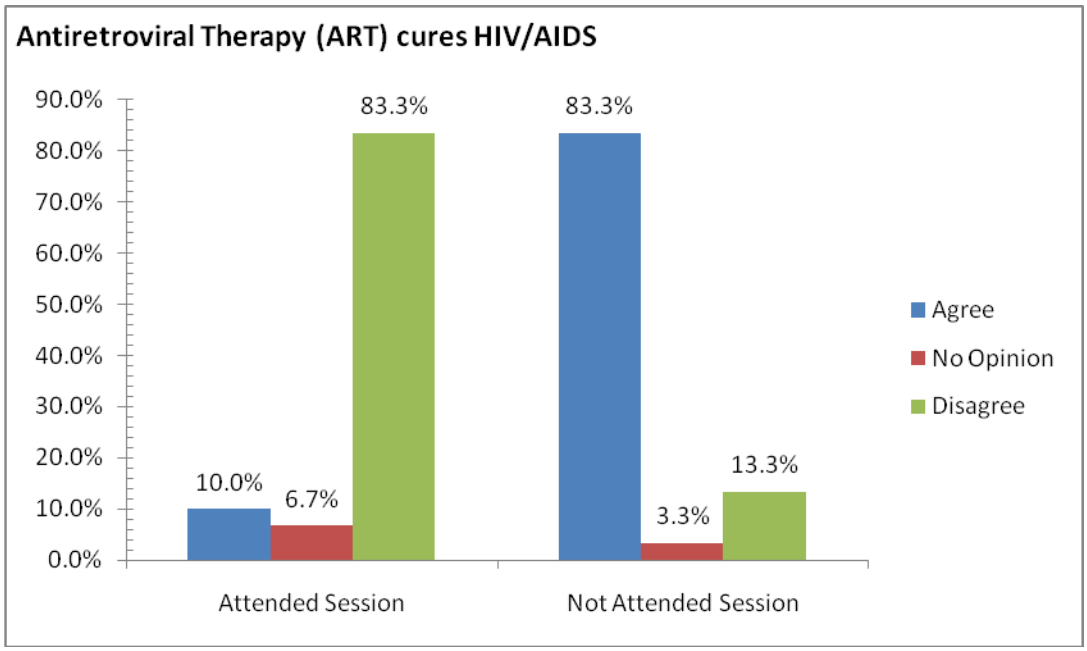
Figure 13:



The majority of the respondents in Group A agreed with the statement while 30% of the Group B respondents agreed.

Q.14

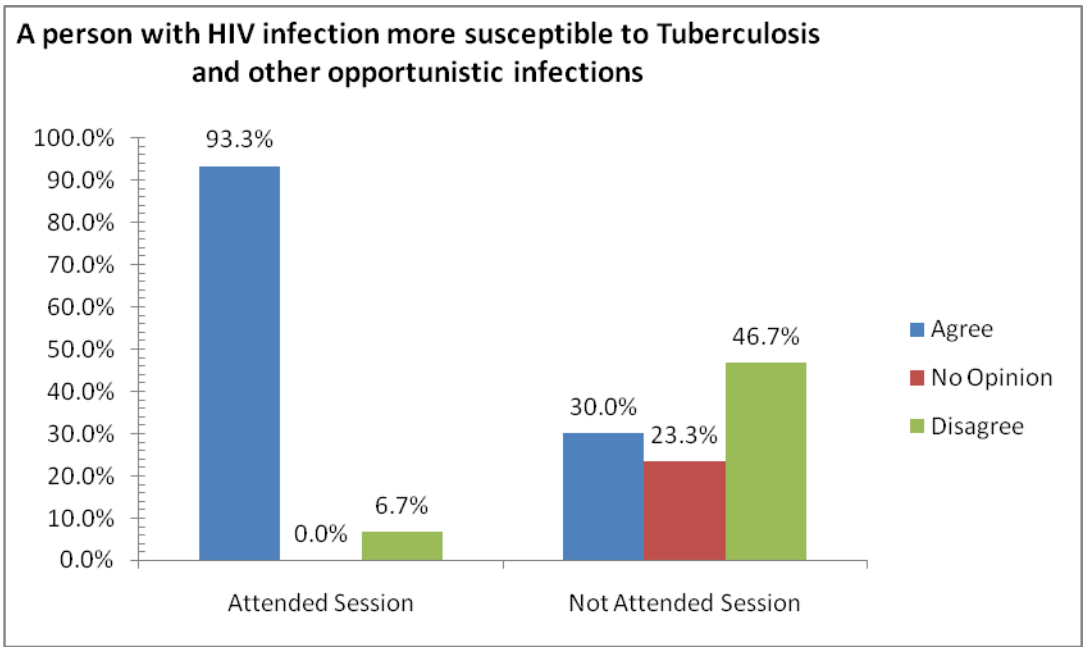
Figure 14:



The majority of the respondents from Group A disagreed with the statement (83.3%) that ART cures HIV/AIDS. In total, 13.3% of respondents from Group B disagreed with the statement.

Q.15

Figure 15:

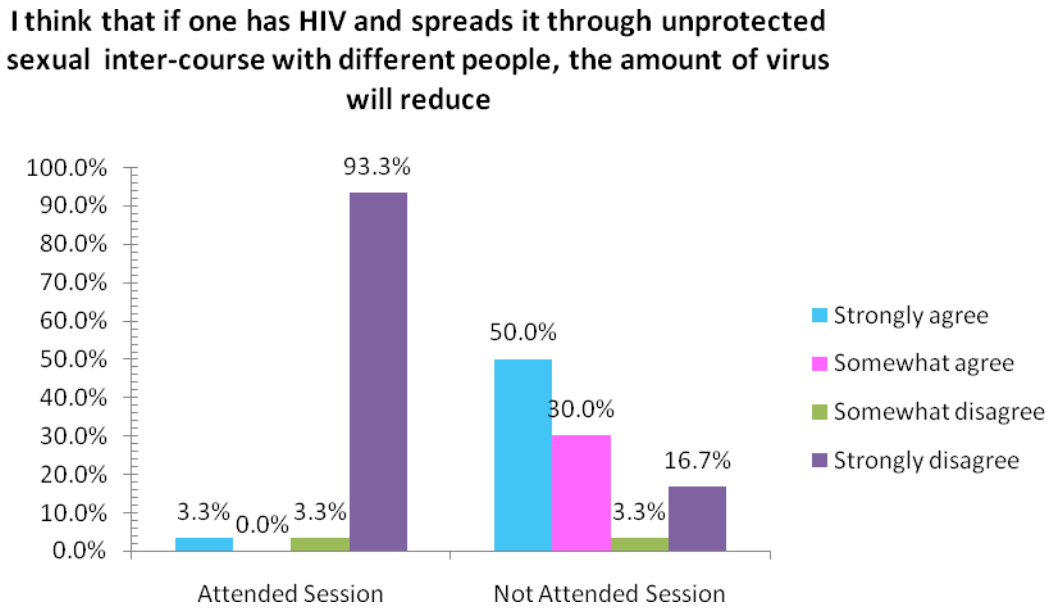


The majority of participants in Group A agreed with the statement while 30% of the participants from Group B agreed with the statement.

4.4 Respondents HIV/AIDS Attitudes

Q.16

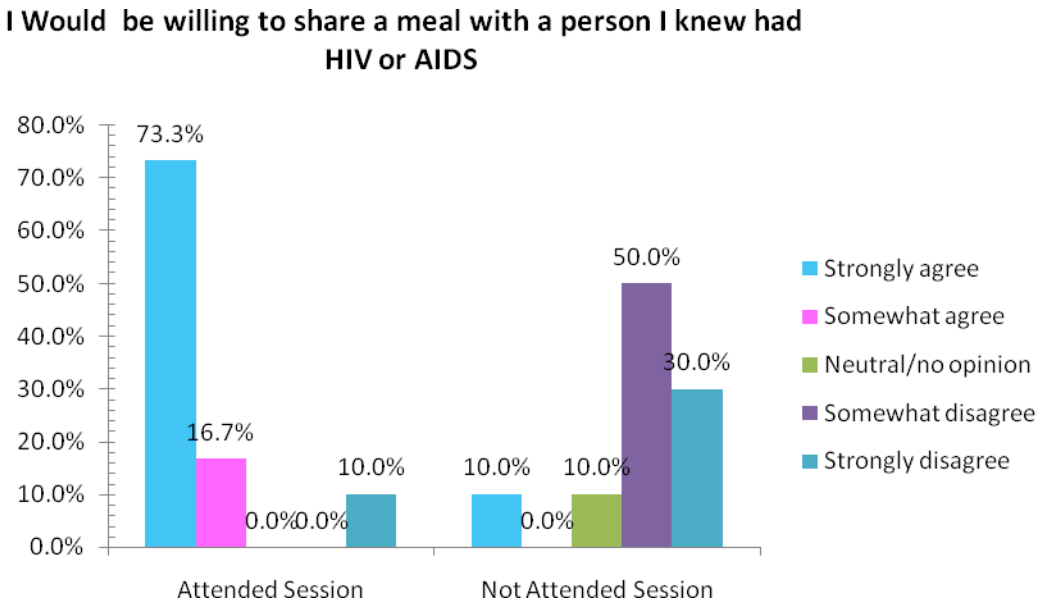
Figure 16:



The majority of the respondents from Group A (93.3%) disagreed with the statement while 16.7% of group B respondents disagreed.

Q.17

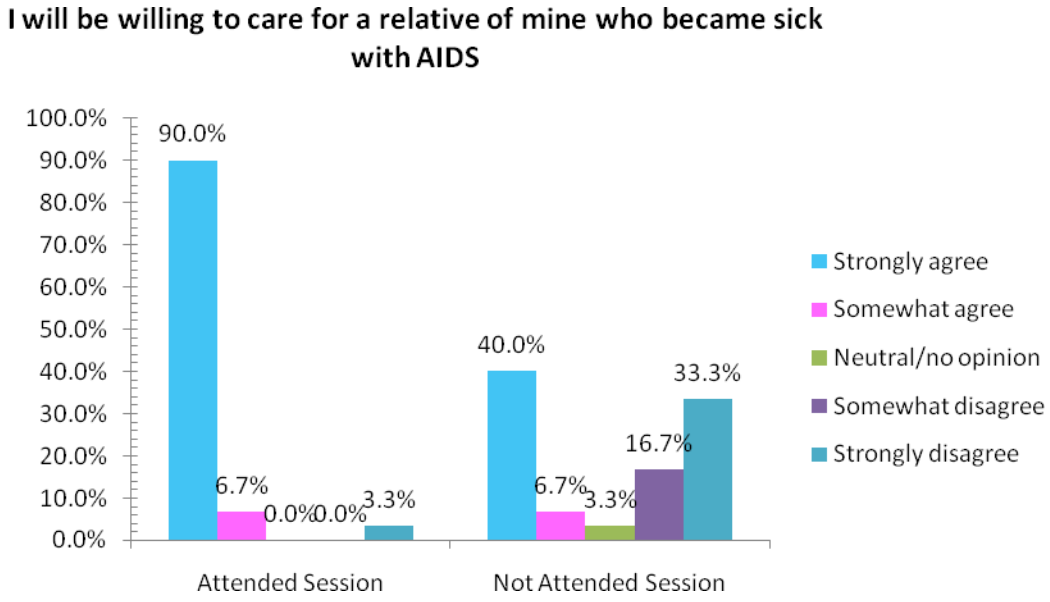
Figure 17:



The majority of the Group A participants agreed with the statement while 10% of Group B participants agreed.

Q.18

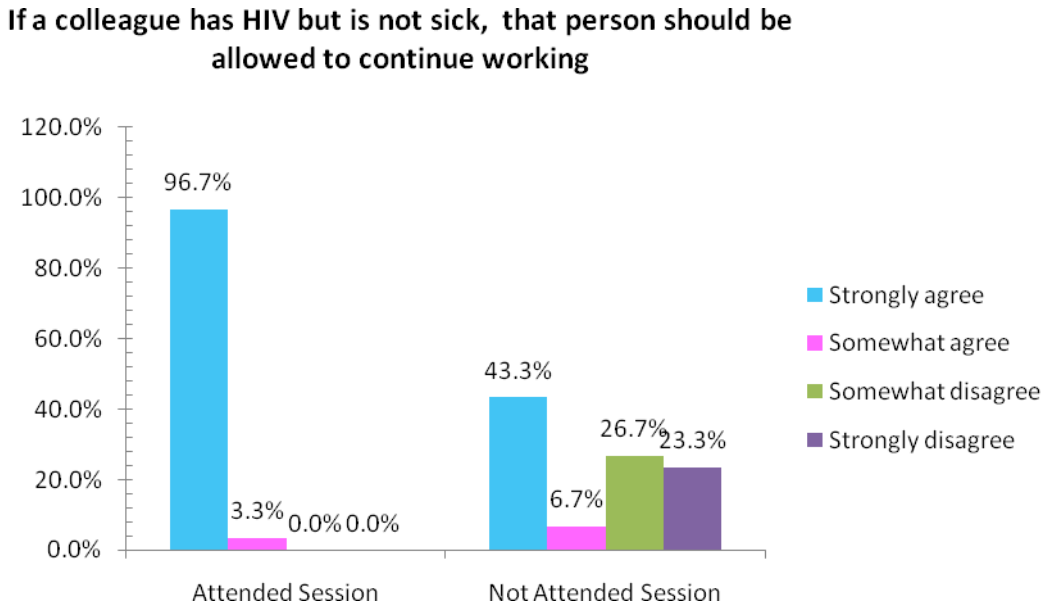
Figure 18:



The majority of the respondents from Group A agreed with the statement while less than 50% of group B respondents agreed or with the statement.

Q.19

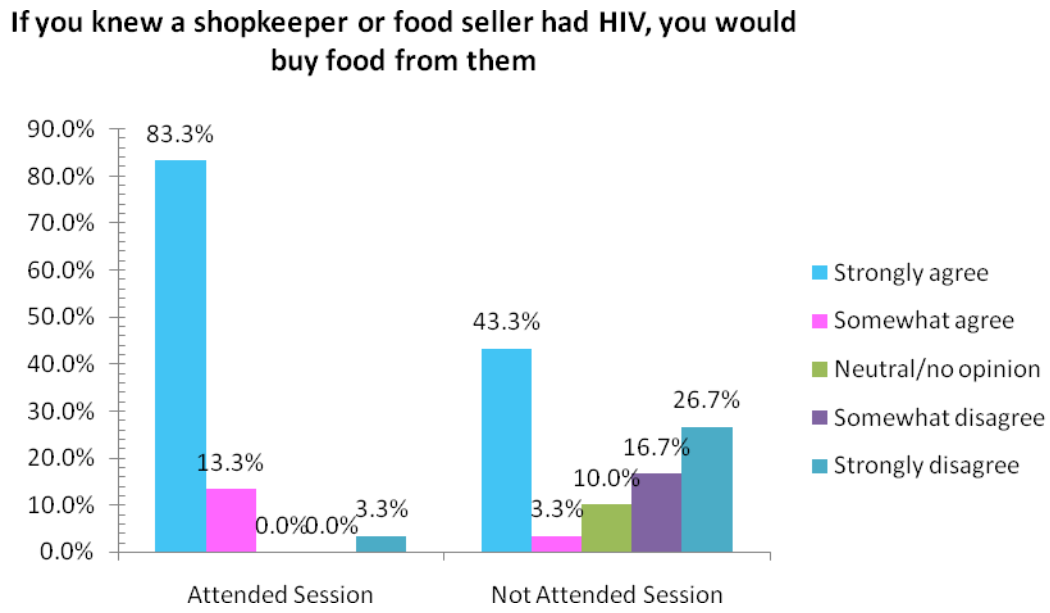
Figure 19:



All of the respondents in Group A agreed with the statement while 50% in Group B agreed with the statement.

Q.20

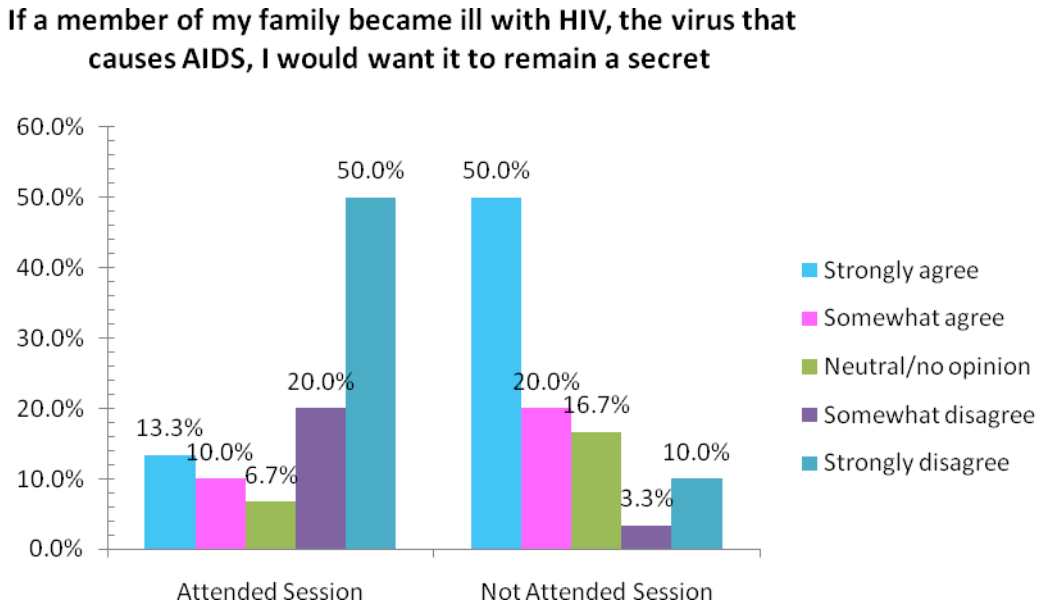
Figure 20:



The majority of the respondents in Group A agreed with the statement (96.6 %) while 46.6% of Group B respondents agreed with the statement.

Q.21

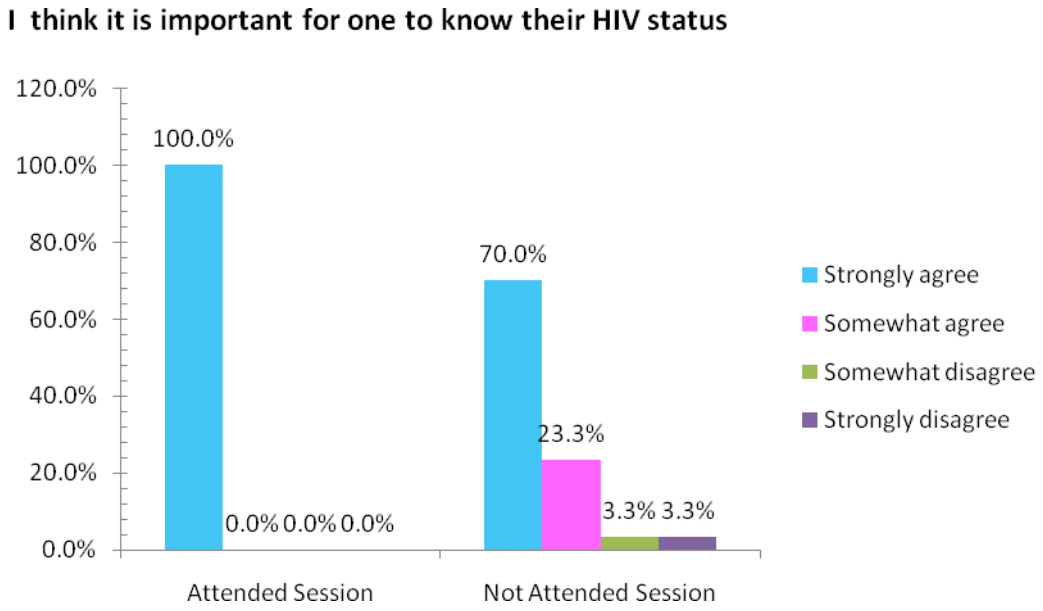
Figure 21:



In total, 23.6%of Group A respondents agreed with the statement while70% of Group B respondents agreed.

Q.22

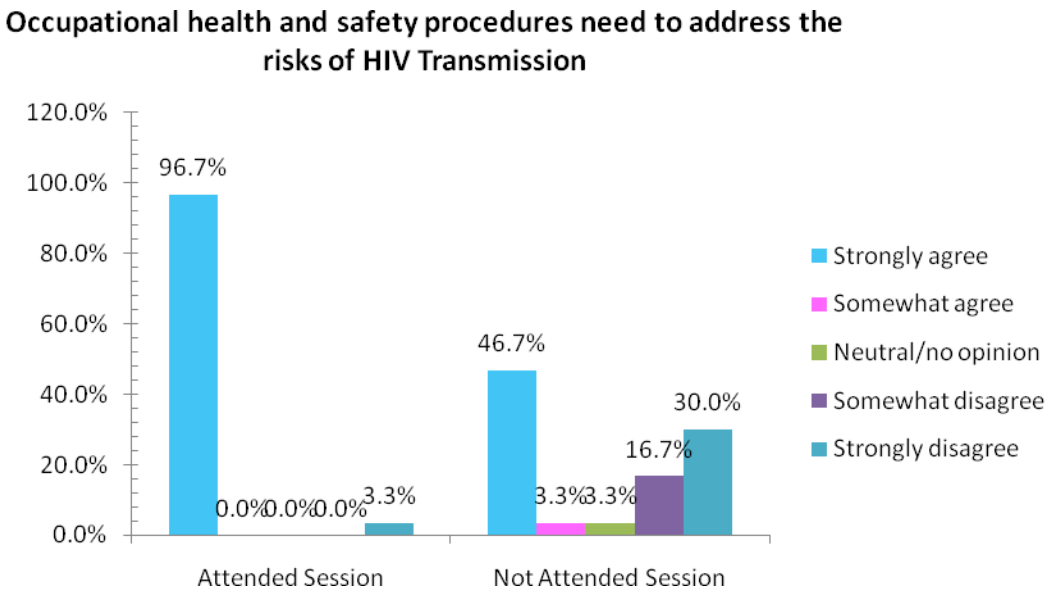
Figure 22:



The majority of the respondents from both groups agreed with the statement that it was important for someone to know their HIV status.

Q.23

Figure 23:

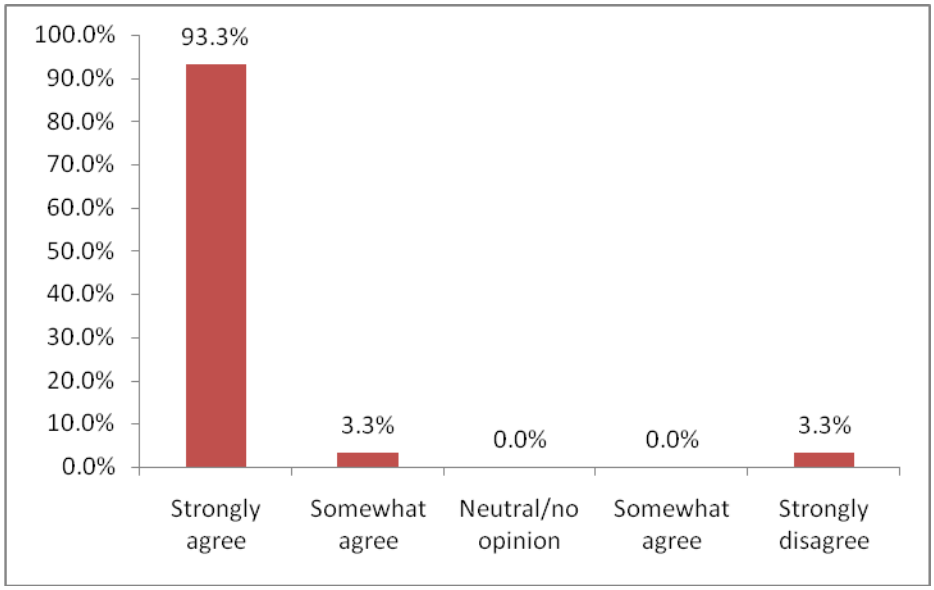


The majority of the respondents from Group A agreed with the statement, while 50% of respondents from Group B agreed.

Q.24

Figure 24:

I am more aware of the dangers of unprotected sex as a result of attending the workplace HIv/AIDS peer education session



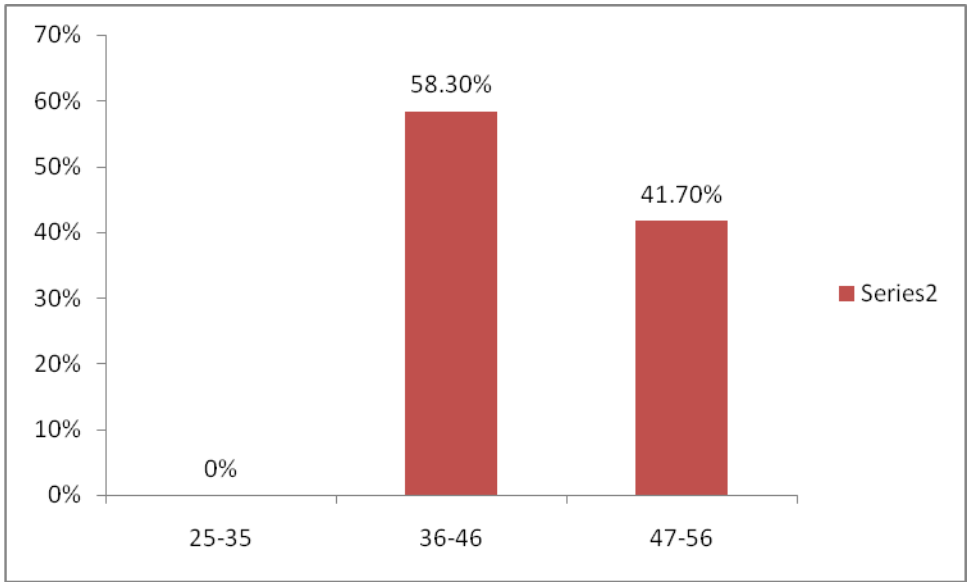
Employees attending peer education sessions had favourable opinions regarding peer education

Section 2: Peer Educators Responses

4.6 Breakdown of Peer Educators Demograhic Data

Q. 25

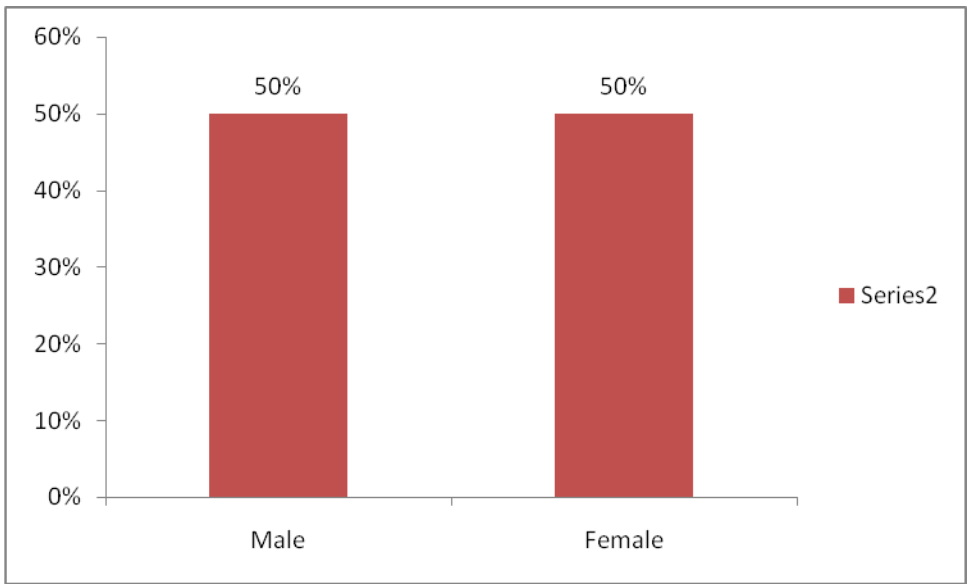
Figure 25: Age Distribution



The majority of the peer educators fell in the age bracket of 36-46 years of age.

Q.26

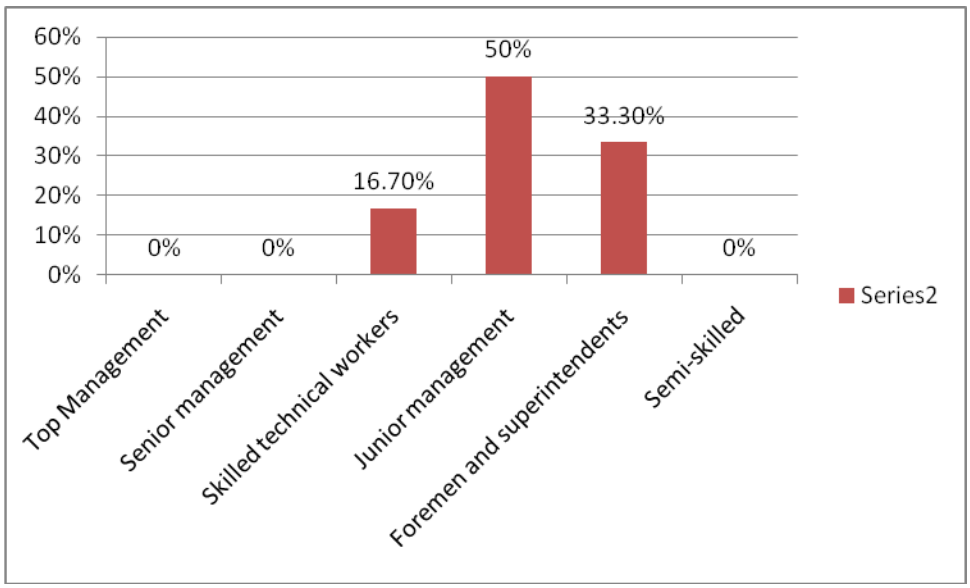
Figure 26: Gender distribution



There was an equal representation of gender amongst the peer educators.

Q.27

Figure 27: Job level



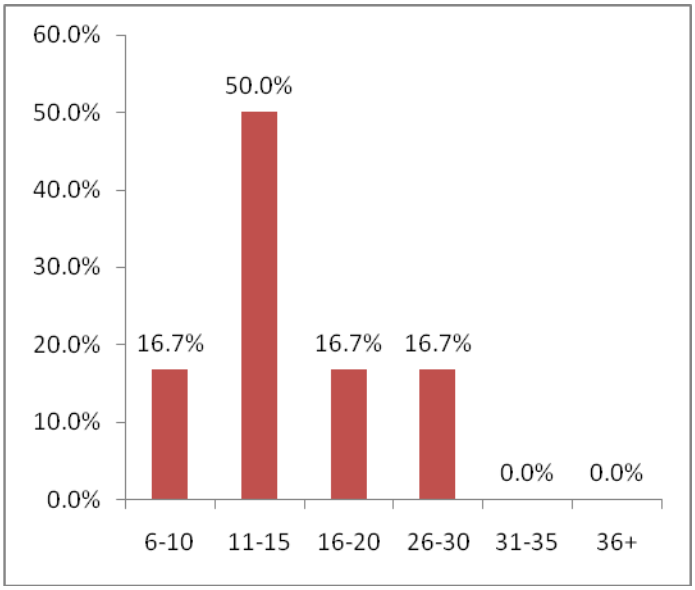
The majority of the peer educators are in junior management who comprise of accounts, personnel, stores and do not deal directly with the workforce on a daily basis unlike the foremen and superintendents who are directly supervise the workforce.

4. 7 Peer Educators Responses

Q.28

How long have you been employed by KPA(Years)

Figure: 28

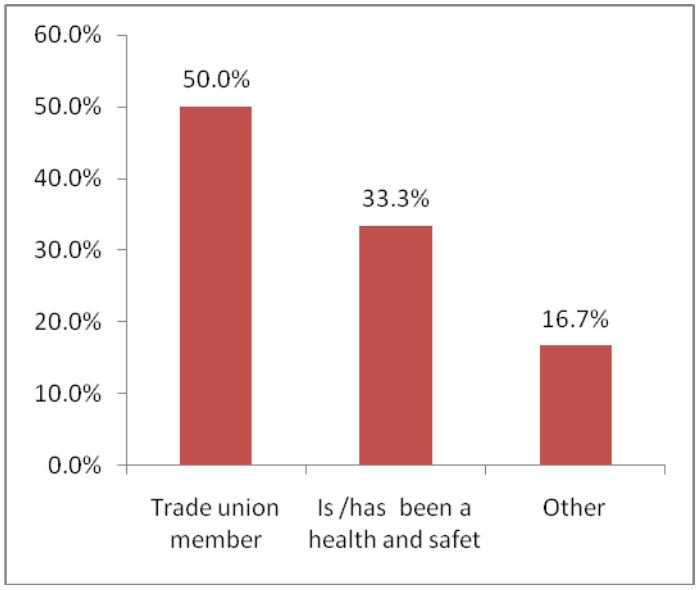


The graph indicates that most of the peer educators have worked fo KPA 6- 10 years for 11-15 years.

Q.29

Are you a member of any workplace organization?

Figure: 29

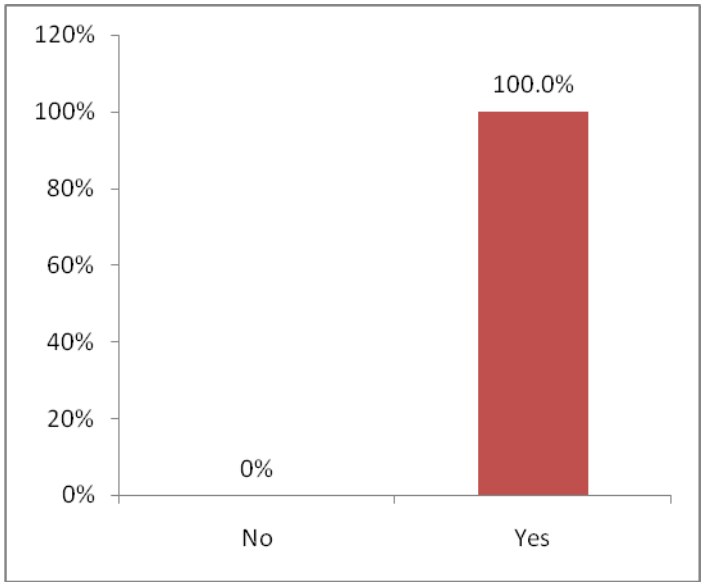


Most of the peer educators are/or have been trade union members.

Q.30

Are you involved in community based HIV/AIDS projects?

Figure: 30

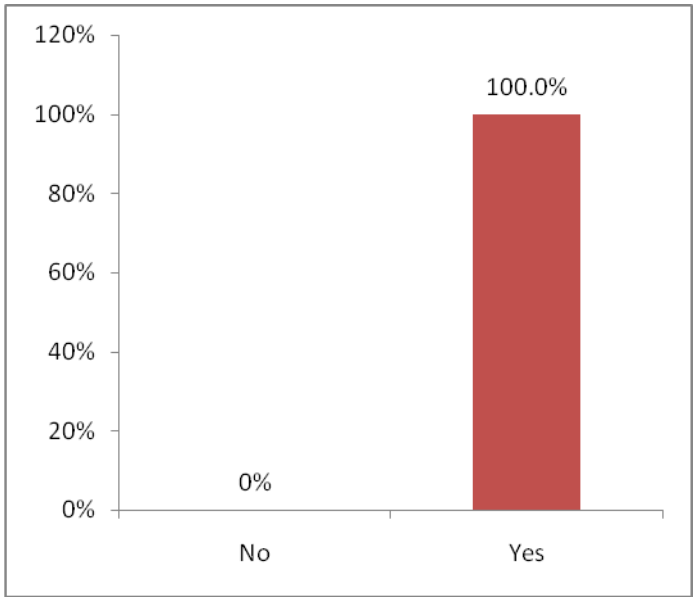


All the peer educators are involved in community based HIV/AIDS projects.

Q.31

Do you know someone well who is HIV positive or who has died of AIDS?

Figure: 31

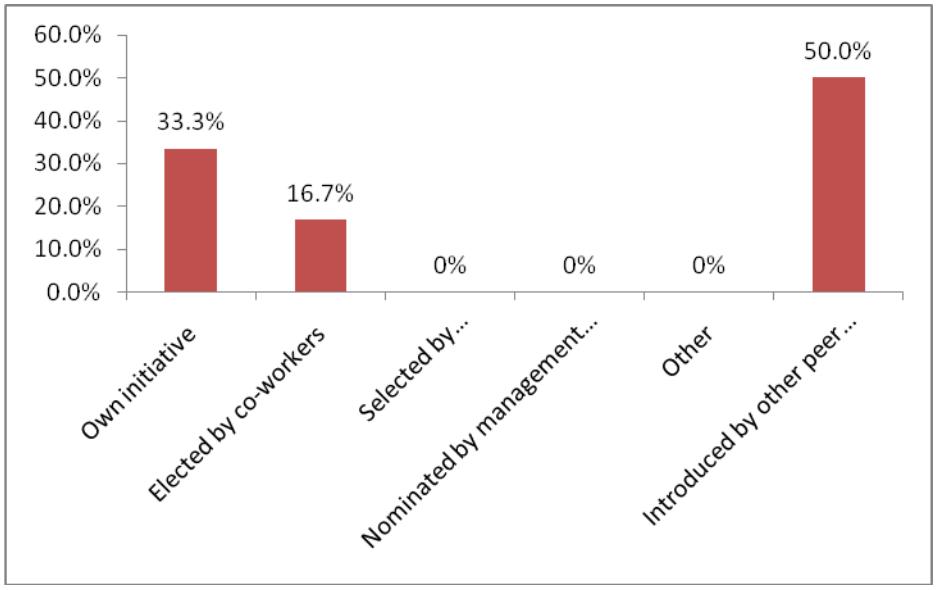


All of the peer educators knew someone with HIV or have known someone who had died of AIDS.

Q.32

What best describes the way in which you became a peer educator

Figure: 32

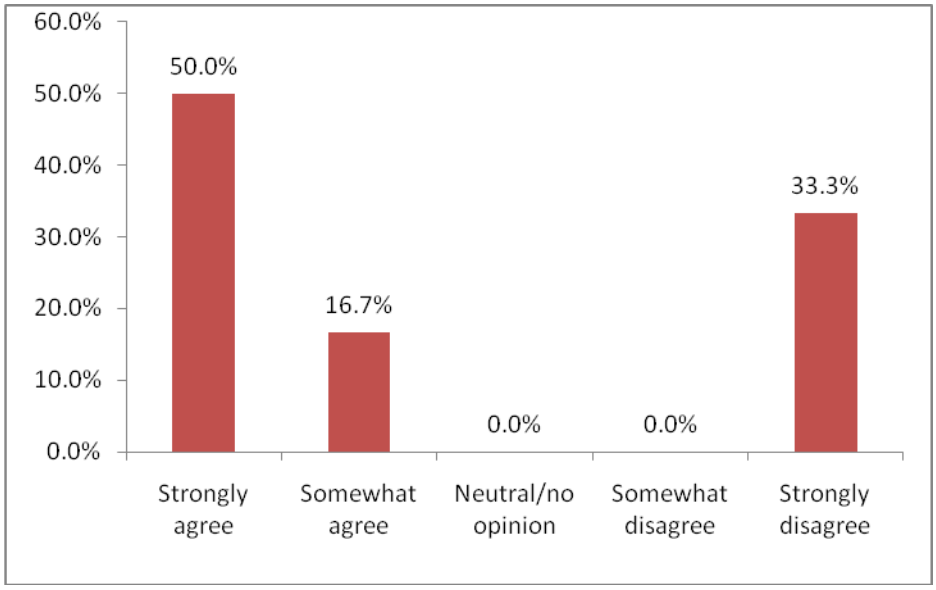


The majority (50%) of the peer educators were introduced to the peer education activities by other peer educators.

Q.33

I think that the training I have received has prepared me for my peer education work

Figure: 33

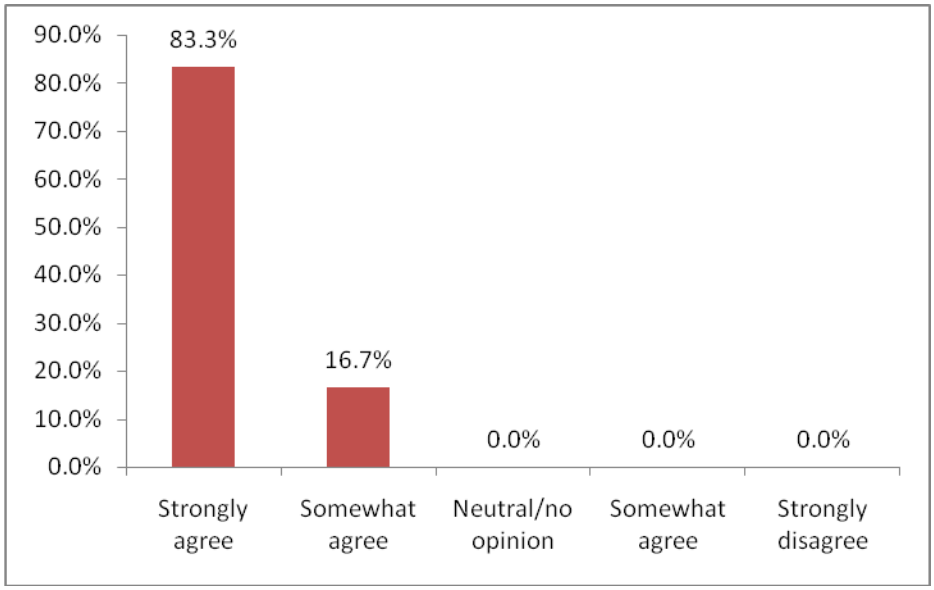


The majority (83%) of the peer educators stated that the peer education training they have received had prepared them for their work.

Q.34

I think that HIV/AIDS will have a negative impact on the company's profit

Figure: 34

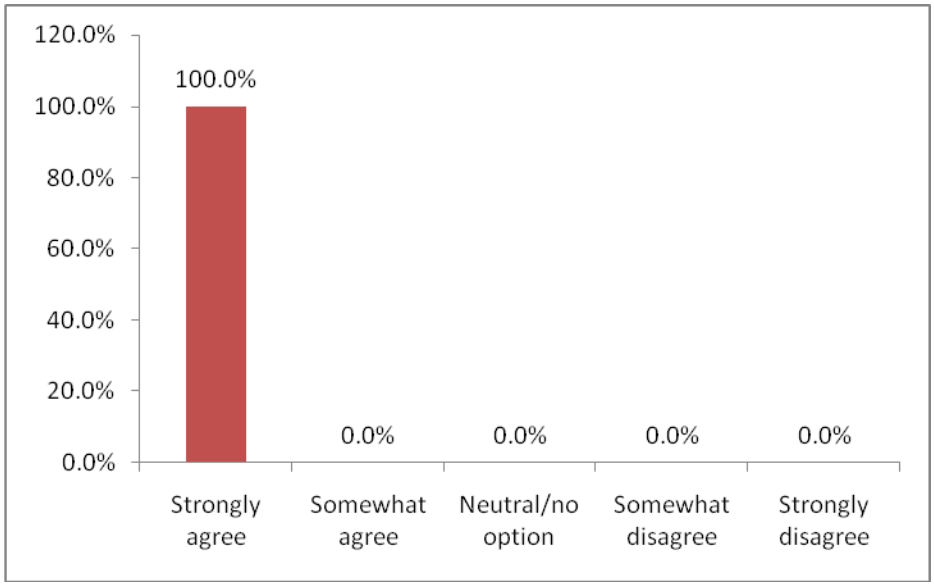


Majority of the peer educators are aware that HIV/AIDS will have a negative impact on their companys profits.

Q.35

I think all employees should be encouraged to attend HIV/AIDS peer education sessions as everyone can benefit from them

Figure: 35

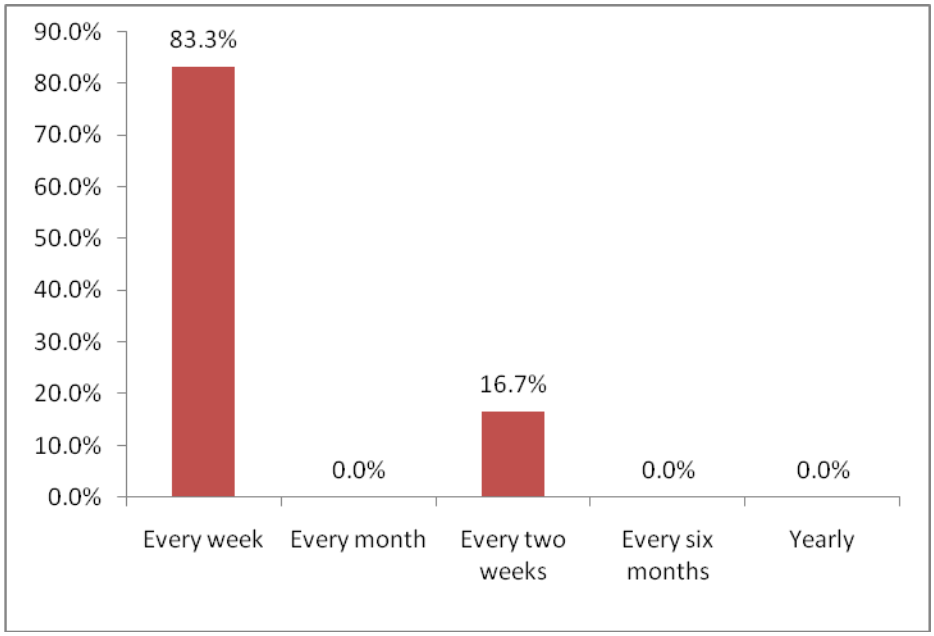


All of the peer educators agreed that everyone should attend HIV/AIDS peer education.

Q.36

How often do you have formal peer education sessions?

Figure: 36

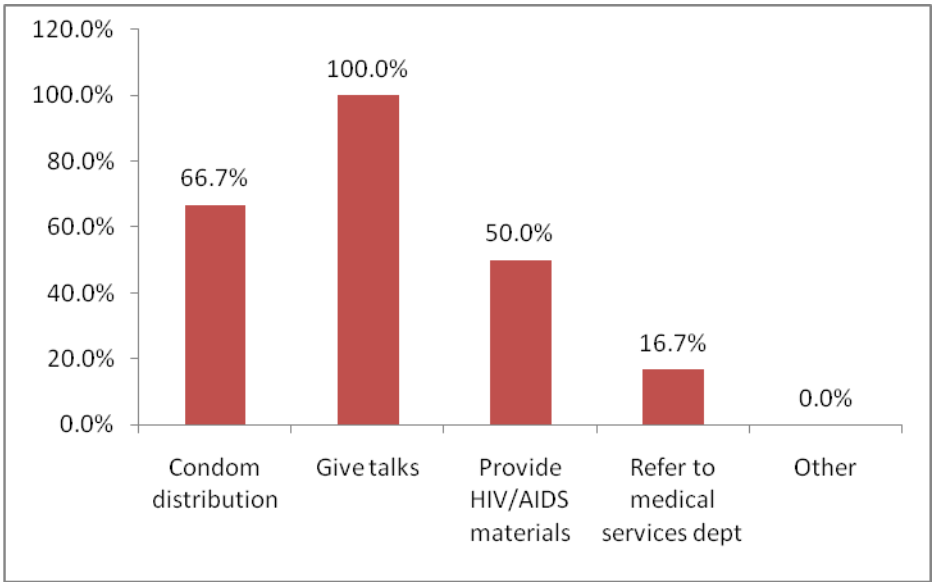


The majority of the peer educators (83%) indicated that they conducted formal peer education sessions every week.

Q.37

What activities do you do specifically?

Figure: 38



The majority of the peer educators listed giving talks as one of their main peer education program activities.

Q.38

What do you think are the most important contributions peer education makes in the response to HIV/ AIDS?

Table 1: Peer educators' contributions to the response of HIV/AIDS

Most important contributions that peer education makes in the response to HIV/AIDS:	Percentage responding
Expand self knowledge and expertise	8.3%
Continue raising awareness of HIV/AIDS and other diseases among peers.	16.7%
Expand self knowledge and expertise on the above	8.3%
Managed to have two daughters who are HIV negative	16.7%
Managed to live positive for the last 13 years	16.7%
Prevent the spread of HIV/AIDS and Live positively for those who are positive, and plan for the future.	16.7%
To enlighten others both at home and at my work place.	16.7%
To have a world which is free of HIV/AIDS	16.7%
To make my fellow workers be educated and understand the goals of peer education.	16.7%
To make sure everyone is informed and trained about peer education work	16.7%
Update not only workers but even at places we leave and the hospital at large.	16.7%

From their reponses which were coded by the researcher as presented in Table 1, the respondents indicated that awareness, education and support were the most important contributions peer education makes in the response to HIV/AIDS.

Q. 39

What are your personal goals in your peer education work?

Table 2: Peer Educators personal goals

Personal goals in peer education work	Percentage responding
Creates a lot of awareness.	16.7%
Educate people	33.3%
Educates on how to take care of the very sick	25.0%
Give knowledge to younger generation and guide them on how they can associate with other people	16.7%
Help the positive live positively by taking treatment	16.7%
Impacting knowledge in a fun way	16.7%
Information	8.3%
Makes people be aware of the disease.	16.7%
Makes them know their status	16.7%
No stigmatization at our homes or even at work places.	8.3%
Peer education creates awareness and hope in almost all the places they happen to go	8.3%
Raising awareness	16.7%
Reduces stigma and discrimination at the work place.	8.3%
Stigma reduction	25.0%
Support positive living	16.7%
The message sent by the peer educators is that almost all the places they happen to go ,they leave a sign of hope for those living with HIV/AIDS	8.3%

From the reponses presented in Table 2, most of the respondents indicated that some of their personal goals in their peer education work was to create awareness, educate people on HIV/AIDS and offer support and care to those that are afflicted by HIV/AIDS.

4.8 Discussion and Interpretation

This section will discuss and interpret the findings of the research.

4.8.1 Respondents Knowledge on HIV/AIDS

The results of the study confirmed that peer education brings about HIV/AIDS knowledge to employees as indicated by the findings. There is a big difference in terms of HIV knowledge between those that attended peer education sessions and those that have not as indicated in responses to questions that were designed to capture their knowledge on HIV/AIDS as demonstrated by figures 6,7,8,9,10.

Those that had attended the peer education sessions appeared to be more aware of the basic facts about HIV/AIDS, and as a result, the levels of understanding on the various aspects of HIV/AIDS for those that had attended peer education sessions appeared to be adequate.

Though inferential statistical analysis was not conducted, the findings seem to indicate that the HIV/AIDS peer education program has increased participants in Group A's HIV/AIDS knowledge levels.

4.8.2 Respondents Attitudes towards HIV/AIDS

The study reflected a shift towards a positive view of people living with HIV/AIDS by the respondents that had attended peer training sessions. Group A respondents also indicated a positive attitude towards supporting individuals who are infected with HIV/AIDS. This was captured when respondents were to give their opinions on questions on their attitudes towards the care and support they are willing to offer to people living with HIV/AIDS (Refer to Figure 18 and 20).

The study also found that Group A respondents seem to display less HIV-related stigma towards people living with HIV/AIDS compared to those in .Group B. Group A respondents also showed more positive attitudes towards accepting a person who is living with HIV and giving sympathy to people who are infected with HIV/AIDS compared to respondents in Group B. The data shows Group B respondents seems more likely to stigmatize HIV positive people compared to respondents in Group A (refer to Figures 17, 18, 19 and 20). Though inferential statistical analysis was not conducted, the findings seem to indicate that the peer education program had a positive impact on participants' attitudes in Group A.

The KPA policy on discrimination of employees living with HIV/AIDS states that managers/supervisors shall ensure that employees do not refuse to work with fellow employees with perceived or actual HIV condition, deny them any services or subject them to unfair treatment. Contravention of this provision shall be tantamount to abuse which is a punishable offence as per the KPA Disciplinary Hand Book march 2008 (KPA workplace policy on HIV/AIDS, 2009).

The findings of the knowledge and attitudes data indicate that exposure to peer education is associated with higher levels of HIV/AIDS knowledge and also lower stigma and discrimination towards people living with HIV/AIDS. The impact of HIV/AIDS on the individual life and knowledge of health services need to be continuously disseminated to promote change in their behaviours.

4.8.3 Peer Educators Responses

Findings on the Peer educators reveal that KPA peer educators are representative of the workforce at large. They are also are active members within and outside the workplace. Most of the peer educators have had firsthand knowledge of HIV/AIDS the peer educators knowing someone well who has HIV or who has died from AIDS. This can be as a result of their peer education role.

The peer educators are satisfied with the knowledge they have acquired from the peer education training and believe it has equipped them to do their peer education work. Most of them displayed positive attitudes towards the peer education program and one would assume therefore that because of this, they are able to actively perform their roles

The findings of the study therefore seem to indicate that the peer education program (as evaluated by the peer educators) has made a positive contribution towards the management of HIV/AIDS in at KPA.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

This chapter will present the conclusions and suggest some recommendations that have come up as a result of the study in order to inform on the improvement of the peer education program at the Kenya Ports Authority and any other workplace.

5.1 Conclusions

The study was conducted to investigate whether peer education has an impact on the management of HIV/AIDS in the given workplace. Based on the findings of this study, the HIV/AIDS peer education program seems to have a positive impact on the knowledge and attitudes of the participants towards HIV/AIDS. This was concluded as a result of the high levels of HIV/AIDS knowledge and the positive attitudes towards people living with HIV/AIDS showed by respondents who had attended peer education sessions as compared to those who had not.

The results of the study revealed that activities being conducted for KPA staff by their peer educators are successful as shown in the high awareness levels and the comparison among target groups.

5.2 Recommendations

- Given the extent to which the HIV/AIDS peer education program conducted by the trained peer educators have impacted on the knowledge and attitudes of the KPA employees who have attended such sessions, this study confirms the importance of peer education programs at KPA. It therefore advocates for the expansion of the Program by KPA Management so that more employees are reached by the peer educators as they have a strong potential to improve HIV/AIDS and attitudes among employees in a workplace.

- The result of the study revealed that activities being conducted for KPA staff by their peer educators are successful as shown in the high awareness levels and the comparison among target groups. There is a necessity to further support and expand the efforts by

KPA medical department to make sure that all staff attends these peer education sessions on HIV/AIDS.

- Due to the positive impact of the peer education program on the knowledge and attitudes of participants, and the positive feedback from the peer educators on the peer education program, there is need to convince more employees to attend peer training sessions and they should be educated on the benefits of attending such sessions. The peer educators should be encouraged to lobby and help convince fellow employees to attend sessions.

- The results of this study could be distributed among staff at KPA to serve as proof of the positive impact of the peer education program and hopefully motivate them to take part in the peer education sessions offered by KPA in the future.

- A similar study on a larger scale needs to be conducted to either confirm or reject the findings of this study.

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ANNEXURE A: RESEARCH QUESTIONNAIRE

SECTION 1: HIV KNOWLEDGE AND ATTITUDES

(Make a cross in the appropriate block)

1. Age group (years)

Between 25 - 35	Between 36 - 46	Between 47 - 56	Older than 56

2. Gender

male	female

3. Job level

Top management	Senior management	Skilled technical workers	Junior management	Foremen and superintendents	Semi-skilled

4. Marital status

single	married	divorced	widowed	Living together

5. Educational level

Primary school	Secondary school	college	undergraduate	Post-graduate

Section 1.1 HIV knowledge

6. There is no cure for HIV/AIDS

Agree	No opinion	Disagree

7. A person get HIV from mosquitoes or other insect bites

Agree	No opinion	Disagree

8. A person get HIV by sharing a meal with someone who is infected with HIV

Agree	No opinion	Disagree

9. It is possible for a person to get HIV through witchcraft

Agree	No opinion	Disagree

10. Having sexual intercourse with a virgin can cure AIDS

Agree	No opinion	Disagree

11. A healthy-looking person can also be infected with HIV, the virus that causes AIDS

Agree	No opinion	Disagree

12. A person can get HIV from working next to an HIV-positive co-worker

Agree	No opinion	Disagree

13. You will have an increased risk of getting HIV during sex if you have a Sexually Transmitted Infection (STI)

Agree	No opinion	Disagree

14. Antiretroviral Therapy (ART) cures HIV/AIDS

Agree	No opinion	Disagree

15. A person with HIV infection more susceptible to Tuberculosis and other Opportunistic infections

Agree	No opinion	Disagree

Section 1.2 HIV attitudes

16. I think that if one has HIV and spreads it around through unprotected sexual Inter-course with different people, the amount of virus will reduce

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

17. I would be willing to share a meal with a person I knew had HIV or AIDS

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

18. I will be willing to care for a relative of mine who became sick with AIDS in my household

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

19. If a colleague has HIV but is not sick, that person should be allowed to continue Working

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

20. If you knew a shopkeeper or food seller had HIV, you would buy food from them

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

21. If a member of my family became ill with HIV, the virus that causes AIDS, I would want it to remain a secret

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

22. I think it is important for one to know their HIV status

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

23. occupational health and safety procedures need to address the risks of HIV transmission

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

24. I am more aware of the dangers of unprotected sex as a result of attending the workplace HIV/AIDs peer education sessions.

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

SECTION 2: TO BE FILLED BY THE PEER EDUCATORS

25. AGE GROUP (years)

Between 25- 35	Between 36- 46	Between 47-56

26. Gender

male	female

27. Job level

Top management	Senior management	Skilled technical workers	Junior management	Foremen and superintendents	Semi-skilled

28. How long have you been employed by KPA(Years)

1 - 5	6 - 10	11 - 15	16 - 20	21 - 25	26 - 30	31 - 35	36+

29. Are you a member of any Workplace organization?

Trade union member	Is/has been a trade union representative	Is /has been a health and safety representative	Other

30. Are you Involved in community based HIV/AIDS projects

YES	NO

31. Do you Know someone well who is HIV positive or who has died of AIDS

YES	NO

32. What best describes the way in which you become a peer educator

Own initiative	Elected by co-workers	Introduced by other peer educators	Selected by management/supervisor	Nominated by management for training	other

33. I think that the training that I have received has prepared me for my peer education work.

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

34. I think that HIV/AIDS will have a negative impact on the company's profit

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

35. I think all employees should be encouraged to attend HIV/AIDS peer education sessions as everyone can benefit from them

Strongly agree	Somewhat agree	Neutral/no opinion	Somewhat disagree	Strongly disagree

36. How often do you have formal peer education sessions

Every week	Every month	Every two weeks	Every six months	yearly

37. What activities do you do specifically?

Condom distribution	Give talks	Provide HIV/AIDS materials	Refer to medical services dept	other

38. What are your personal goals in your peer education work

39. What do you think are the most important contributions peer education makes in the response to HIV/AIDS
